

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01452

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. LENGTH OF STAY IN 1b 1 yr - 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland House of Correction Hospital				d. STREET ADDRESS 10115 McKenny Avenue			
3. NAME OF DECEASED (Type or print) First Maurice Middle Winfield Last Agee				4. DATE OF DEATH Month Feb. Day 22 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-21		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Wilson Pontiac Auto Dealers		11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asa Agee			14. MOTHER'S MAIDEN NAME Erma Stump				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 232-26-8297		17. INFORMANT Maryland House of Correction Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles S. Petty</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/23/60	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/25/60		22c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		22d. LOCATION (City, town, or county) (State) PARSONS, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR FEB 24 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
1950 CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX MALE		3. AGE 68	
4. RACE WHITE		5. BIRTH DATE 1882		6. BIRTH PLACE MD	
7. DECEASED AT HOME		8. PLACE OF DEATH HOME		9. DATE OF DEATH 1950	
10. TIME OF DEATH 10:00 AM		11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL	
13. SIGNATURE OF DECEASED WILLIAM J. BROWN		14. SIGNATURE OF WITNESS WILLIAM J. BROWN		15. SIGNATURE OF DECEASED WILLIAM J. BROWN	
16. SIGNATURE OF WITNESS WILLIAM J. BROWN		17. SIGNATURE OF DECEASED WILLIAM J. BROWN		18. SIGNATURE OF WITNESS WILLIAM J. BROWN	
19. SIGNATURE OF DECEASED WILLIAM J. BROWN		20. SIGNATURE OF WITNESS WILLIAM J. BROWN		21. SIGNATURE OF DECEASED WILLIAM J. BROWN	
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97. SIGNATURE OF DECEASED WILLIAM J. BROWN		98. SIGNATURE OF WITNESS WILLIAM J. BROWN		99. SIGNATURE OF DECEASED WILLIAM J. BROWN	
100. SIGNATURE OF WITNESS WILLIAM J. BROWN		101. SIGNATURE OF DECEASED WILLIAM J. BROWN		102. SIGNATURE OF WITNESS WILLIAM J. BROWN	



RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 1950
 This certificate is a true and correct copy of the original as filed in the office of the State Department of Health, Baltimore, Maryland.
 WITNESSED BY THE CLERK OF THE STATE DEPARTMENT OF HEALTH - BALTIMORE 1950
 CLERK OF THE STATE DEPARTMENT OF HEALTH - BALTIMORE 1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG258 3-7-60 et

1495

CERTIFICATE OF DEATH

01454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 35 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3 Vol. 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. STREET ADDRESS 1372 N. Woodyear St				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alexander Anderson				4. DATE OF DEATH Month February Day 25 Year 19 60											
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 18, 1870		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Month 1 Day 15 Hours 15 Min.		11. IF UNDER 24 HRS. Month 1 Day 15 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Copper & Brass Co.				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-10-0714				17. INFORMANT Rachel Wallace				Address 1926 Penna. Ave. Balto. 17, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 604 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vesical calculi DUE TO (c) ? yrs.												INTERVAL BETWEEN ONSET AND DEATH 5 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile mental changes															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 21, 1960 , to Feb. 25, 1960 , that I last saw the deceased alive on Feb. 20, 1960 , and that death occurred at 5 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue DATE SIGNED Feb. 26, 1960 ACTUAL SIGNATURE James M. Pair M.D. PHYSICIAN'S NAME (Type) James M. Pair, M.D. Baltimore 23, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-29-60				22c. NAME OF CEMETERY OR CREMATORY mtauburn				22d. LOCATION (City, town, or county) md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Nelson								ADDRESS 1348 N. Carrollton St				24a. REC'D BY REGISTRAR DATE FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-134

CERTIFICATE OF DEATH

1952

See back for instructions

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male / Female]</p>		<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date]</p>		<p>5. PLACE OF BIRTH [Place]</p>	
<p>6. OCCUPATION [Occupation]</p>		<p>7. MARITAL STATUS [Married / Single / Widowed / Divorced]</p>		<p>8. CAUSE OF DEATH [Cause]</p>		<p>9. MANNER OF DEATH [Natural / Accidental / Suicide / Homicide]</p>		<p>10. PLACE OF DEATH [Place]</p>	
<p>11. DATE OF DEATH [Date]</p>		<p>12. TIME OF DEATH [Time]</p>		<p>13. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>14. SIGNATURE OF REGISTRAR [Signature]</p>		<p>15. SIGNATURE OF WITNESS [Signature]</p>	
<p>16. SIGNATURE OF DECEASED [Signature]</p>		<p>17. SIGNATURE OF NEXT OF KIN [Signature]</p>		<p>18. SIGNATURE OF CLERK [Signature]</p>		<p>19. SIGNATURE OF JUDGE [Signature]</p>		<p>20. SIGNATURE OF SHERIFF [Signature]</p>	

ORIGINAL FILED IN 60710

RECEIVED
 DIVISION OF
 RECORDS & COMMUNICATIONS
 BALTIMORE, MARYLAND

1496 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Convalescent Home</u>				d. STREET ADDRESS <u>2209 W. Lafayette Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Anderson</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16, 1878</u>	9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Henrietta</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-8780</u>		17. INFORMANT Address <u>Earl Brown 2209 W. Lafayette Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Baltimore</u>	(County) <u>Baltimore</u>	(State) <u>Md.</u>		
21. I certify that I attended the deceased from <u>Feb. 15, 1960</u> , to <u>Feb. 22, 1960</u> , that I last saw the deceased alive on <u>Feb. 20, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>400 N. Carrollton Ave. Balto. 23, Md.</u> DATE SIGNED <u>Feb. 23, 1960</u>							
ACTUAL SIGNATURE <u>James M. Pair</u> M.D.							
PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Hulst</u> ADDRESS <u>918 Druid Hill Ave.</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No.

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VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1498

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Reg. Dist. No.

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VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4mo. 13 yrs. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1340 Argyle Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Marvin Bailey				4. DATE OF DEATH Month Day Year 2 15 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1904?	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 026X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Nervous System Syphilis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/11 , 19 46 , to 2/15 , 19 60 , that I last saw the deceased alive on 2/15 , 19 60 , and that death occurred at 4:12 M., from the causes and on the date stated above. ADDRESS (Sheet, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 2/15/60 ACTUAL SIGNATURE Hildegard Heard Reissman M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 2/15/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Cedar Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson				24a. REC'D BY REGISTRAR DATE FEB 29 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

11-22

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. HEIGHT</p> <p>13. WEIGHT</p> <p>14. BUILD</p> <p>15. HAIR</p> <p>16. EYES</p> <p>17. SKIN</p> <p>18. TENDRILS</p> <p>19. TEETH</p> <p>20. NAILS</p> <p>21. FINGERS</p> <p>22. TOES</p> <p>23. FEET</p> <p>24. HANDS</p> <p>25. WRISTS</p> <p>26. ELBOWS</p> <p>27. SHOULDERS</p> <p>28. NECK</p> <p>29. THROAT</p> <p>30. CHEST</p> <p>31. BACK</p> <p>32. LIMBS</p> <p>33. JOINTS</p> <p>34. MOVEMENTS</p> <p>35. SENSES</p> <p>36. MENTAL</p> <p>37. PHYSICAL</p> <p>38. GENERAL</p> <p>39. SPECIAL</p> <p>40. OTHER</p>		<p>1. DATE OF DEATH</p> <p>2. TIME OF DEATH</p> <p>3. PLACE OF DEATH</p> <p>4. CAUSE OF DEATH</p> <p>5. MANNER OF DEATH</p> <p>6. MEDICAL HISTORY</p> <p>7. SURGICAL HISTORY</p> <p>8. DRUGS</p> <p>9. TREATMENT</p> <p>10. NURSING</p> <p>11. DIALYSIS</p> <p>12. TRANSFUSION</p> <p>13. ORGAN DONOR</p> <p>14. ORGAN RECIPIENT</p> <p>15. OTHER</p>
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1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

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20. NAILS

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22. TOES

23. FEET

24. HANDS

25. WRISTS

26. ELBOWS

27. SHOULDERS

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29. THROAT

30. CHEST

31. BACK

32. LIMBS

33. JOINTS

34. MOVEMENTS

35. SENSES

36. MENTAL

37. PHYSICAL

38. GENERAL

39. SPECIAL

40. OTHER

1455 CERTIFICATE OF DEATH

Reg. Dist. No.

01458

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Rt-3, Box-458		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle POWELL Last BARKSDALE				4. DATE OF DEATH Month February Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer				10b. KIND OF BUSINESS OR INDUSTRY Electrical Engineer		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William BARKSDALE				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. William E Barksdale Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liverneck's cirrhosis and 581.1 DUE TO severe dehydration - secondary Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 7 days DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 31 , 19 60 , to Jan. 31 , 19 60 , that I last saw the deceased alive on January 31 , 19 60 , and that death occurred at 12:08 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sylvia M. Lim M.D.				ADDRESS (Street, city or town, state) Mayo Road DATE SIGNED 2/1/60			
PHYSICIAN'S NAME (Type) Sylvia Lim				Edgewater, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1960		22c. NAME OF CEMETERY OR CREMATORY All Hallows Court		22d. LOCATION (City, town, or county) (State) Birdsville Co Co Me	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md				24a. REC'D BY REGISTRAR FEB 4 1960		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

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1456 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 829 West St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle N. Last BASIL		4. DATE OF DEATH Month February Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1875
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat market	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 30 7946	
INFORMANT Mr. Mike Basil - Son-		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernicious anemia; carcinoma of stomach			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 19 57 , to Feb. 19 60 , that I last saw the deceased alive on Feb. 4 , 19 60 , and that death occurred at 8:35A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Hedeman		ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 2/5/60	
PHYSICIAN'S NAME (Type) John L. Hedeman		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
ADDRESS Annapolis, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1955

State of Maryland

County of Anne Arundel

City of Annapolis

State of Maryland

County of Anne Arundel

City of Annapolis

Frank

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White

White

Intention

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Intention

DATE OF DEATH: 11 - 11 - 1955

CAUSE OF DEATH: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G256 2-11-60 et

1457

CERTIFICATE OF DEATH

01460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TRUXTON HGTS.		d. STREET ADDRESS TRUXTON HGTS.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE C BASIL SR		4. DATE OF DEATH Month Day Year FEBRUARY 1 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1867
9. AGE (In years last birthday) 92 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Const. General	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Basil		14. MOTHER'S MAIDEN NAME Aletha Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-16-5313	
INFORMANT Mrs Lillian Martin- Daughter- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1, 1953 to Feb. 1, 1960 that I last saw the deceased alive on Jan 31, 1959 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) February 1, 1960			
ACTUAL SIGNATURE James R. Martin		M.D. _____	
PHYSICIAN'S NAME (Type) JAMES R. MARTIN MD		6 Shaw Street, Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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b. COUNTY **Anne Arundel**

10 Annapolis

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Year

19 60

IF UNDER 24 HRS

Hours	Min.
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12. CITIZEN OF WHAT COUNTRY?

U.S.

Unknown

Address:

INFORMANT Address
MRS FRANK STALLINGS

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INTERVAL BETWEEN
ONSET AND DEATH

--	--

10 yr.

Palmerus inflatus

19. WAS AUTOPS PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

21. I **certify** that I attended the deceased from Feb. 17, 1960, to Feb. 20, 1960, that I last saw the deceased alive on Feb. 20, 1960, and that death occurred at 6:45 A. M. from the causes and on the date stated above.

Frank M. Shipley

M.D.

121 Cathedral St.,

2/20/60

Frank M. Shipley

Annapolis, Md.

22d. LOCATION (City, town, or county)

23. FUNERAL DIRECTOR'S SIGNATURE *[Signature]*

ADDRESS *Franklin, Md*

24a. REC'D BY REGISTRAR

24b REGISTRAR'S SIGNATURE
[Signature]

07407

1428 CENTRAL DISTRICT

1428

James M. Smith

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James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01462

1459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 HR.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>BLANCHARD</u> Last <u>BLANCHARD</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 FEB 60</u>
9. AGE (In years last birthday) <u>1 1/2 HR.</u> yes.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>30</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Riggs</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Blanchard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Riggs</u>		Address <u>Friendship Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATUREITY</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HR.</u> <u>1 1/2 HR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 FEB</u> , 19 <u>60</u> , to <u>20 FEB</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>20 FEB</u> , 19 <u>60</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James I. Hudson, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1 River Rd. RIVER CLUB ESTATES 21 FEB 60</u>	
PHYSICIAN'S NAME (Type) <u>JAMES I. HUDSON, JR.</u>		<u>EDGEWATER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 2-23-11am</u>		22b. DATE THEREOF <u>2-23-11am</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>McKendrick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>		ADDRESS <u>Arma</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

2063182XUO

1499 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton Md.</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Blanche M. Bland</u>				4. DATE OF DEATH <u>Feb 24th 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/13/25</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>J. FREDERICK LUTZ</u>				14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS Lillian McSherry Churchton Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>generalized arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>60</u> , to <u>2-24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>60</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sam H. Hulm</u> M.D.				ADDRESS (Street, city or town, state) <u>Baltimore Md.</u> DATE SIGNED <u>2-25-60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Henderson</u> ADDRESS <u>Salisbury Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 29 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 11

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1500 CERTIFICATE OF DEATH

01464

1. PLACE OF DEATH a. COUNTY <u>Chesapeake</u> <u>Anne Arundel Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>A. Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ann Murray Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maudie G. Bogue</u>				4. DATE OF DEATH <u>Feb 15</u> 19 <u>60</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04-20-1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Viola Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mary J. Sauer</u> Address <u>Ann Murray Home, Millersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Interstital Hemorrhage</u> (b) <u>Cardiovascular trauma with complications</u> (c) <u>Generalized Edema</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Edema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 <u>8/7/59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/7/59</u> to <u>2/15</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>60</u> and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Lipskey</u>				22b. DATE SIGNED <u>2/15/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>				22d. ADDRESS <u>ODEM TON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb 18, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Discernible words include:]

George Johnson
born [illegible]
 died [illegible]
 cause of death [illegible]
 place of death [illegible]
 signed [illegible]
 date [illegible]

CERTIFICATE OF DEATH

01465

Reg. Dist. No. 27

1501

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> - MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN IB <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. STREET ADDRESS <u>8 Washington Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Joseph</u> Last <u>Bolt</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 February 1960</u>	
9. AGE (In years last birthday) <u>9</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Lewis Bolt</u>		14. MOTHER'S MAIDEN NAME <u>Eleanore Josephine Milwicz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>James Lewis Bolt (Father)</u>		Address <u>8 Washington Ave Severn, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia with peritonitis and meningitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sepsis</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9 February 1960</u> to <u>10 February 1960</u> , that I last saw the deceased alive on <u>10 February 1960</u> , and that death occurred at <u>10:30 A</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roger C Moyer Capt. MC</u>				ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Fort George G. Meade, Md</u>			
PHYSICIAN'S NAME (Type) <u>ROGER C. MOYER, CAPT., MC</u>				DATE SIGNED <u>10 Feb 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 Feb. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Meyer Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carling & Kraus</u>			

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 17 Film G257 2-25-60 et

1460

CERTIFICATE OF DEATH

01466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle L. Last BOTHE		4. DATE OF DEATH Month February Day 19 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1925
9. AGE (In years lost birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BERNICE LEE KAUFFMAN		14. MOTHER'S MAIDEN NAME GRACE HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. EDWARD B. BOTHE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mekutabre carcinoma of right ovarian origin 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 40 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 22, 1960 , to Feb. 18, 1960 , that I last saw the deceased alive on Feb. 18, 1960 , and that death occurred at 1:50A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Hedeman		ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 2/19/60	
PHYSICIAN'S NAME (Type) John L. Hedeman		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-22-1960	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Scayler Sons		24a. REC'D BY REGISTRAR FEB 23 '60	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hand	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

— 2 —

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.1461
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01467

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle BOYCE Last BOYCE		4. DATE OF DEATH Month February Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Peter Boyce		14. MOTHER'S MAIDEN NAME (First Name Unk.) Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mrs. Clyde C. McElanahan (2)	
17. INFORMANT Mrs. Clyde C. McElanahan (2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 19, 1960 to Feb. 28, 1960 , that (I) (we) last saw the deceased alive on Feb. 28, 1960 , and that death occurred at 10:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 2/29/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-60	
23c. NAME OF CEMETERY OR CREMATORY Detrick Cemetery		23d. LOCATION (City, town, or county) (State) Detrick Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 3 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hanna		25c. DATE MAR 3 '60	

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____

for and in consideration of the sum of _____ Dollars

to _____

the receipt of which is hereby acknowledged

do hereby certify that _____

is the true and correct copy of the original

as the same appears from the records of the _____

1502 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>C.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Best Gate</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Best Gate</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>77 Habelle Ave.</i>		d. STREET ADDRESS <i>77 Habelle Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>E.</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>2</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-1-1898</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>2</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Rosette Foote</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>216-32-2451</i>	
17. INFORMANT <i>Mary Jones</i>		Address <i>Best Gate, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>481X Dehydration</i> DUE TO (b) <i>Infectious Diarrhea</i> DUE TO (c) <i>Viral influenza</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-7 days</i> <i>2 wk</i> <i>1 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/23</i> , 19 <i>60</i> , to <i>2/14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/14</i> , 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Faye W. Allen</i> M.D.		ADDRESS (Street, city or town, state) <i>625 Cathedral St Annapolis Md</i> DATE SIGNED <i>2/15/60</i>	
PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-18-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		ADDRESS <i>—</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>FEB 18 '60</i>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1503 CERTIFICATE OF DEATH

02798

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
c. LENGTH OF STAY IN 1b <u>All his life</u>				d. STREET ADDRESS <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Furnace Branch Road, box 768</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bobby Lee Brown</u>				4. DATE OF DEATH <u>February 13th</u> 19 <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/58</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months		IF UNDER 24 HRS. <u>3</u> Days		Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Early Brown</u>				14. MOTHER'S MAIDEN NAME <u>Ethel I. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr and Mrs. J.E. Brown (parents).</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>480X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>La Grippe</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>14 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2/11/60</u> 19 <u> </u> , to <u>2/13/60</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/10/60</u> 19 <u> </u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Gustave H. Faubert</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				22d. ADDRESS <u>5 First Avenue, S.E. Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Magdaleny Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas Wilson</u>				ADDRESS <u>1000 Sunnyside Ave</u>		25a. RECEIVED BY REGISTRAR <u>MAR 16 60</u>	
25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>							

1903



1504

CERTIFICATE OF DEATH

01469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 11mo. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 3308 Elgin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle Brown Last Brown				4. DATE OF DEATH Month 2 Day 2 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1873	
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min.		11. IF UNDER 24 HRS. Hours 28 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Boldland				14. MOTHER'S MAIDEN NAME Emma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 355x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO (c) Senile Brain Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour 2 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 2/4 , 19 58 , to 2/2 , 19 60 , that I last saw the deceased alive on 2/2 , 19 60 , and that death occurred at 10:02 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/3/60			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				Crownsville State Hospital, Md. 2/3/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-60		22c. NAME OF CEMETERY OR CREMATORY mt. Calvary		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Halsted				ADDRESS 918 D. Hill Rd		24a. REC'D BY REGISTRAR FEB 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1890		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. DECEASED AT HOME Yes		12. PLACE OF DEATH Home		13. DATE OF DEATH 1935		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS 2 weeks		18. PRESENT ILLNESS Angina Pectoris		19. PREVIOUS ILLNESS Hypertension		20. MEDICAL HISTORY None	
21. NAME OF PHYSICIAN Dr. J. H. Smith		22. NAME OF HOSPITAL None		23. NAME OF NURSE None		24. NAME OF BURIAL PLACE St. Mary's Cemetery		25. NAME OF FUNERAL HOME None	
26. SIGNATURE OF PHYSICIAN J. H. Smith		27. SIGNATURE OF DECEASED None		28. SIGNATURE OF WITNESSES None		29. SIGNATURE OF REGISTRAR None		30. SIGNATURE OF CLERK None	

REGISTRATION DIVISION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the county or city in which the deceased resided at the time of death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>St Mary</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>3 years 11 months</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mechanicsville Route 2</i>		d. STREET ADDRESS <i>18X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Williams Bush</i>		4. DATE OF DEATH <i>February 27 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-22-1875</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Williams</i>		14. MOTHER'S MAIDEN NAME <i>Rosetta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Toxemia</i> <i>450.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Dehydration and Starvation</i> DUE TO (c) <i>Gangrene of Right Foot with General Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months and 4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome associated with Senile</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Brain Disease</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>March 10, 1956</i> to <i>February 27, 1960</i> that I last saw the deceased alive on <i>February 27, 1960</i> , and that death occurred at <i>11:05</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Enrique J del Campo</i>		DATE SIGNED <i>Feb 28/1960</i>	
PHYSICIAN'S NAME (Type) <i>Enrique J del Campo</i>		ADDRESS (Street, city or town, state) <i>Crownsville State Hospital</i>	
22a. BURIAL-CREATION, REMOVAL (Specify) <i>3-3-60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>CARVER MEMORIAL MARYLAND M. D.</i>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN TRHINES-PO</i>		24a. REC'D BY REGISTRAR <i>3 MAR 3 '60</i>	
ADDRESS <i>3015 12TH ST NE</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Huns</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1462

CERTIFICATE OF DEATH

Reg. Dist. No.

01471

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Annapolis, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 32 Pleasant St. Plaza Manor Nursing Home	
3. NAME OF DECEASED (Type or print) First Daisy Middle Gross Last Butler		4. DATE OF DEATH Month February Day 18 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 4, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) A. A. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Gross		14. MOTHER'S MAIDEN NAME Lucinda Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
INFORMANT Emma James - 32 Pleasant St.		Address Annapolis - Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Hypertensive Vascular Disease Grade IV			INTERVAL BETWEEN ONSET AND DEATH 30 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/28 , 19 60 , to 2/18 , 19 60 , that I last saw the deceased alive on 2/18 , 19 60 , and that death occurred at 5:20A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodore H. Johnson		ADDRESS (Street, city or town, state) 37 Calvert Street Annapolis, Md.	
PHYSICIAN'S NAME (Type) Dr. Theodore H. Johnson		DATE SIGNED 2/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 21, 1960	22c. NAME OF CEMETERY OR CREMATORY ANNAPOHIS - NECK	22d. LOCATION (City, town, or county) (State) ANNAPOHIS - Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks		ADDRESS ANNAPOHIS - Md.	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04171

CERTIFICATE OF DEATH

1962



Name (Printed)

Name (Printed)

Date of Birth

Place of Birth

Sex

Place of Death

Time of Death

Age

Sex

Color

Height

Weight

SS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1463

CERTIFICATE OF DEATH

Reg. Dist. No.

01472

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN IB 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DEATH Deale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph CAPPE				4. DATE OF DEATH Month Day Year February 23 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAPER HANGING				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME CHARLES M. CAPPE				14. MOTHER'S MAIDEN NAME MARY E. MERCER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578030884		17. INFORMANT JAMES A. CAPPE Address 135 OVERBROOK DR. CASTLEBURY, FLA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Ca undetected, probably pancreas DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 12, 1960 to Feb. 22, 1960 , that I last saw the deceased alive on Feb. 22, 1960 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wilbur F. Smith 2/23/1960 M.D.							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Wilbur F. Smith				Shadyside, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/60		22c. NAME OF CEMETERY OR CREMATORY Deale		22d. LOCATION (City, town, or county) (State) Deale Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Hardaway				ADDRESS Salisbury		24a. REC'D BY REGISTRAR DATE FEB 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~adjoining~~ ^{adjoining} papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2852

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Jackson Ave			d. STREET ADDRESS 10 Jackson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle JACKSON Last CARROLL			4. DATE OF DEATH Month 22 Day 24 Year 19 60		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? ?	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anne Arundel County	
13. FATHER'S NAME Westley Jackson			14. MOTHER'S MAIDEN NAME Barbara Oliver		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mack Carroll Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease DUE TO (c) Unknown					INTERVAL BETWEEN ONSET AND DEATH Several hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2-5- , 19 60 , to 2-24- , 19 60 , that I last saw the deceased alive on 2-24- , 19 60 , and that death occurred at 1:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Richard H. Hunt		M.D. 100 Cherry Lane, Glen Burnie		DATE SIGNED 2-27-60	
PHYSICIAN'S NAME (Type) RICHARD H. HUNT					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-60		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem	
				22d. LOCATION (City, town, or county) (State) Anne Arundel County	
23. FUNERAL DIRECTOR'S SIGNATURE Clay O. Wilson			24a. REC'D BY REGISTRAR DATE MAR 1 6 '60		
			24b. REGISTRAR'S SIGNATURE Wm L. Hunt		

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

1506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 10mo. 39 yrs. 22days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Clark				4. DATE OF DEATH Month 2 Day 8 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilaterally 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Hour 19 Month 11 Day 60 Year 19 60 p. m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) ----- (County) ----- (State) -----							
21. I certify that I attended the deceased from 3/16 , 19 60 , to 2/8 , 19 60 , that I last saw the deceased alive on 2/8 , 19 60 , and that death occurred at 7:45P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/9/60 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 2/9/60 PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore City Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson				ADDRESS 1611-13 N. Arlington Ave		24a. REC'D BY REGISTRAR DATE 11 11 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1507

CERTIFICATE OF DEATH

01474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>1437-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>343 Cannon Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Cotton</u> Last <u>Cotton</u>				4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 3, 1934</u>	
				9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pastry Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewin Blackston</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Confluent</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1/26</u> , 19 <u>60</u> , to <u>2/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>60</u> , and that death occurred at <u>2:00A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>2/5/60</u> ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>2/5/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buttertown, Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Woxton</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bessie Walker</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01174

MAKALAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1901

Form 100-100

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1856	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer		7. CAUSE OF DEATH Heart Disease		8. PLACE OF DEATH Home	
9. DATE OF DEATH 1901		10. TIME OF DEATH 10:00 AM		11. SIGNATURE OF DECEASED James H. Harris		12. SIGNATURE OF WITNESS John Doe	
13. SIGNATURE OF DECEASED James H. Harris		14. SIGNATURE OF WITNESS John Doe		15. SIGNATURE OF DECEASED James H. Harris		16. SIGNATURE OF WITNESS John Doe	
17. SIGNATURE OF DECEASED James H. Harris		18. SIGNATURE OF WITNESS John Doe		19. SIGNATURE OF DECEASED James H. Harris		20. SIGNATURE OF WITNESS John Doe	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John Doe		23. SIGNATURE OF DECEASED James H. Harris		24. SIGNATURE OF WITNESS John Doe	
25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS John Doe		27. SIGNATURE OF DECEASED James H. Harris		28. SIGNATURE OF WITNESS John Doe	
29. SIGNATURE OF DECEASED James H. Harris		30. SIGNATURE OF WITNESS John Doe		31. SIGNATURE OF DECEASED James H. Harris		32. SIGNATURE OF WITNESS John Doe	
33. SIGNATURE OF DECEASED James H. Harris		34. SIGNATURE OF WITNESS John Doe		35. SIGNATURE OF DECEASED James H. Harris		36. SIGNATURE OF WITNESS John Doe	
37. SIGNATURE OF DECEASED James H. Harris		38. SIGNATURE OF WITNESS John Doe		39. SIGNATURE OF DECEASED James H. Harris		40. SIGNATURE OF WITNESS John Doe	
41. SIGNATURE OF DECEASED James H. Harris		42. SIGNATURE OF WITNESS John Doe		43. SIGNATURE OF DECEASED James H. Harris		44. SIGNATURE OF WITNESS John Doe	
45. SIGNATURE OF DECEASED James H. Harris		46. SIGNATURE OF WITNESS John Doe		47. SIGNATURE OF DECEASED James H. Harris		48. SIGNATURE OF WITNESS John Doe	
49. SIGNATURE OF DECEASED James H. Harris		50. SIGNATURE OF WITNESS John Doe		51. SIGNATURE OF DECEASED James H. Harris		52. SIGNATURE OF WITNESS John Doe	
53. SIGNATURE OF DECEASED James H. Harris		54. SIGNATURE OF WITNESS John Doe		55. SIGNATURE OF DECEASED James H. Harris		56. SIGNATURE OF WITNESS John Doe	
57. SIGNATURE OF DECEASED James H. Harris		58. SIGNATURE OF WITNESS John Doe		59. SIGNATURE OF DECEASED James H. Harris		60. SIGNATURE OF WITNESS John Doe	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESS John Doe		63. SIGNATURE OF DECEASED James H. Harris		64. SIGNATURE OF WITNESS John Doe	
65. SIGNATURE OF DECEASED James H. Harris		66. SIGNATURE OF WITNESS John Doe		67. SIGNATURE OF DECEASED James H. Harris		68. SIGNATURE OF WITNESS John Doe	
69. SIGNATURE OF DECEASED James H. Harris		70. SIGNATURE OF WITNESS John Doe		71. SIGNATURE OF DECEASED James H. Harris		72. SIGNATURE OF WITNESS John Doe	
73. SIGNATURE OF DECEASED James H. Harris		74. SIGNATURE OF WITNESS John Doe		75. SIGNATURE OF DECEASED James H. Harris		76. SIGNATURE OF WITNESS John Doe	
77. SIGNATURE OF DECEASED James H. Harris		78. SIGNATURE OF WITNESS John Doe		79. SIGNATURE OF DECEASED James H. Harris		80. SIGNATURE OF WITNESS John Doe	
81. SIGNATURE OF DECEASED James H. Harris		82. SIGNATURE OF WITNESS John Doe		83. SIGNATURE OF DECEASED James H. Harris		84. SIGNATURE OF WITNESS John Doe	
85. SIGNATURE OF DECEASED James H. Harris		86. SIGNATURE OF WITNESS John Doe		87. SIGNATURE OF DECEASED James H. Harris		88. SIGNATURE OF WITNESS John Doe	
89. SIGNATURE OF DECEASED James H. Harris		90. SIGNATURE OF WITNESS John Doe		91. SIGNATURE OF DECEASED James H. Harris		92. SIGNATURE OF WITNESS John Doe	
93. SIGNATURE OF DECEASED James H. Harris		94. SIGNATURE OF WITNESS John Doe		95. SIGNATURE OF DECEASED James H. Harris		96. SIGNATURE OF WITNESS John Doe	
97. SIGNATURE OF DECEASED James H. Harris		98. SIGNATURE OF WITNESS John Doe		99. SIGNATURE OF DECEASED James H. Harris		100. SIGNATURE OF WITNESS John Doe	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vaughn First Middle Last		4. DATE OF DEATH Month February Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1919
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Abraham Cromwell		14. MOTHER'S MAIDEN NAME Etta Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address Myrtle Diggs R. 2 Box 585 Anna	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x DUE TO Bronchial Pneumonia Bilateral Severe INTERVAL BETWEEN ONSET AND DEATH 1 da. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viral Pneumonitis 3 das. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Toxic Nephroses Bilateral			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 8, 19 60 , to Feb. 8, 19 60 , that I last saw the deceased alive on Feb. 8, 1960 , and that death occurred at 9:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Cathedral St., DATE SIGNED ACTUAL SIGNATURE Faye W. Allen M.D. PHYSICIAN'S NAME (Type) Faye W. Allen Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2-13-1960	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Broadneck	22d. LOCATION (City, town, or county) (State) Shilmore Md
23. FUNERAL DIRECTOR'S SIGNATURE William Reese # Anna Md		24a. REC'D BY REGISTRAR DATE FEB 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1966

State of Illinois

County of Cook

In the Circuit Court of Cook County, Illinois

vs.

People of the State of Illinois

Defendant

Plaintiff

State of Illinois

County of Cook

In the Circuit Court of Cook County, Illinois

vs.

People of the State of Illinois

Defendant

Plaintiff

State of Illinois

County of Cook

In the Circuit Court of Cook County, Illinois

1508

CERTIFICATE OF DEATH

Reg. Dist. No. 01476

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 8mo. 4days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 304 Caroline Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Oakie Middle Last Davis				4. DATE OF DEATH Month 2 Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 25, 1893	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper-Lumber Yard				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Doc Davis				14. MOTHER'S MAIDEN NAME Rebecca			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 206-05-4457		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour 2 m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 6/25 , 19 59 , to 2/29 , 19 60 , that I last saw the deceased alive on 2/29 , 19 60 and that death occurred at 5:40A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.					
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		DATE SIGNED 2/29/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-2 1960		22c. NAME OF CEMETERY OR CREMATORY University of Md.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS -----		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
						24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01130

1503

Washington, D.C.

Bellevue

U.S. Army Medical Center

1903

October 22, 1903

Virginia

Richmond

U.S. Army Medical Center

Washington, D.C.

U.S. Army Medical Center

October 22, 1903

U.S. Army Medical Center

Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1509 CERTIFICATE OF DEATH

01477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>116 3rd ave</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>DIERINGER</u> Last <u>DIERINGER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	IF UNDER 24 HRS. Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY DIERINGER</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of prostate a metas-</u> <u>177X</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p) <u>Hypertensive cardiovascular disease (?)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>53</u> , to <u>2/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/9</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Deibel</u>		ADDRESS (Street, city or town, state) <u>1226 House St Balto 30 Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Harry Deibel</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Brownstown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>		ADDRESS <u>130 E Fort Ave</u>	
24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Reg. Dist. No.

VS A15 (4)
15M 9/58

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4/7/60
mnb1510
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64094

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 3 mo. 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Albert Middle Dudley Last Dudley		4. DATE OF DEATH Month 2 Day 1 Year 19 60				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months 3 Days 0 Hours 1 Min. 4	IF UNDER 24 HRS. Months 3 Days 0 Hours 1 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia and Parotitis DUE TO 537X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACBS c ACUD						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/9 19 15 to 2/1 19 60 , that (I) (we) last saw the deceased alive on 2/1 19 60 , and that death occurred at 3:30 PM from the causes and on the date stated above.						
22a. SIGNATURE <i>Hildegard Heard Reissman</i>		M.D. Hildegard Heard Reissman, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/2/60
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City, town, or county) Baltimore, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Thomas E. Kelson, Baltimore, Md.				25a. REC'D BY REGISTRAR DATE APR 13 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kelson</i>

Res. (B, City) verified by phone to
funeral Director 4/19/60
ams.

794

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1511

CERTIFICATE OF DEATH

01479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 1 Yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena d. STREET ADDRESS Rt. 2, Box 117-C e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie E. Middle Edwards Last 4. DATE OF DEATH Month 2 Day 12 Year 19 60		5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH January 21, 1884 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Worker 10b. KIND OF BUSINESS OR INDUSTRY Farm 11. BIRTHPLACE (State or foreign country) Town Neck, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Henry Edwards 14. MOTHER'S MAIDEN NAME Annie Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. D.P. W. A.A.Co. Mr. Anderson INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized hypertrophic osteoarthritis. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-11 , 19 59 , to 2-12 , 19 60 , that I last saw the deceased alive on Feb. 6 , 19 60 , and that death occurred at 1:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Ave. DATE SIGNED Feb. 12, 1960 ACTUAL SIGNATURE James M. Pair M.D. 400 N. Carrollton Ave., Balto., Md. PHYSICIAN'S NAME (Type) James M. Pair—M. D. 400 N. Carrollton Ave., Balto., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-15-1960 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist 22d. LOCATION (City, town, or county) (State) Magothy, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson ADDRESS 916 Pa. Ave. Balto. # 1, Md. 24a. REC'D BY REGISTRAR FEB 16 60 24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

01110

CERTIFICATE OF DEATH

1911

RECEIVED
JAN 10 1911
U.S. DEPT. OF HEALTH

Blank certificate form with horizontal lines for text entry.

1466 CERTIFICATE OF DEATH

Reg. Dist. No.

01480

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1254 Tyler Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William Middle T. Last ELLIOTT		4. DATE OF DEATH Month February Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1879	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Elliott				14. MOTHER'S MAIDEN NAME Margaret Seeney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Laura E. Shockley 1254 Tyler Ave. Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Feb. 8, 19 60 , to Feb. 9, 19 60 , that I last saw the deceased alive on Feb. 9, 1960 and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck		M.D. _____		ADDRESS (Street, city or town, state) 41 Southgate Ave.,		DATE SIGNED 2/9/60	
PHYSICIAN'S NAME (Type) Edward S. Beck		Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-60		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie				ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR FEB 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2

2520

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1467 CERTIFICATE OF DEATH

Reg. Dist. No.

01481

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 105 Conduit St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lillian Middle E. Last FLOOD				4. DATE OF DEATH Month February Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1895		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME T. FRANK MYERS				14. MOTHER'S MAIDEN NAME MARY E. SCIBLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -		17. INFORMANT T. DUFF MYERS		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA; CHRONIC PHLEBOTOMY							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 20, 1960 to Feb. 24, 1960 , that I last saw the deceased alive on Feb. 24, 1960 , and that death occurred at 12:50P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave., DATE SIGNED							
ACTUAL SIGNATURE Edward S. Beck				M.D. 41 Southgate Ave.,			
PHYSICIAN'S NAME (Type) Edward S. Beck				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 27-1960		Hillcrest Memorial		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR FEB 29 60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

01481

NAME OF DECEASED JOHN J. SMITH		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1880		PLACE OF BIRTH New York	
FATHER'S NAME JOHN J. SMITH		MOTHER'S NAME MARY J. SMITH		DATE OF DEATH 1925		PLACE OF DEATH Baltimore		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
OCCUPATION Clerk		EDUCATION High School		MARITAL STATUS Married		RELIGION Roman Catholic		PREVIOUS ILLNESS None		HISTORY OF ALCOHOLIC DRINKING None	
DATE OF INTERVIEW 1925		INTERVIEWER Dr. J. Smith		DATE OF DEATH 1925		PLACE OF DEATH Baltimore		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Dr. J. Smith		SIGNATURE OF DECEASED John J. Smith		SIGNATURE OF WITNESS Mary J. Smith		SIGNATURE OF DECEASED John J. Smith		SIGNATURE OF WITNESS Mary J. Smith		SIGNATURE OF DECEASED John J. Smith	

1468

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 months 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle ANITA Last GANTT		4. DATE OF DEATH Month February Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BASIL QUEEN		14. MOTHER'S MAIDEN NAME MARGARET GOODRICH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Bronchial Pneumonia with Bilateral Hydrothorax and Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Diabetes Mellitus DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 wk Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. WAS AUTOPSY PERFORMED? Infarction sup. portion of right cerebral artery YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Infarction sup. portion of right cerebral artery from occlusion	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 12, 1959 , to Feb. 19, 1960 , that I last saw the deceased alive on Feb. 19, 1960 , and that death occurred at 4:40 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Faye W. Allen		ADDRESS (Street, city or town, state) 62 Cathedral St.,	
PHYSICIAN'S NAME (Type) Faye W. Allen		DATE SIGNED Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 24-60	22c. NAME OF CEMETERY OR CREMATORY ST-MARY'S	22d. LOCATION (City, town, or county) (State) ANNAPOLIS-Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. HICKS III		ADDRESS ANNAPOLIS-Md.	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01182

CERTIFICATE OF DEATH

1482

ACQUITTANCE

Attest: _____
Date: _____
Place: _____
Signature: _____
Name: _____
Age: _____
Sex: _____
Race: _____
Color: _____
Height: _____
Weight: _____
Build: _____
Complexion: _____
Eyes: _____
Hair: _____
Manner of Death: _____
Cause of Death: _____
Time of Death: _____
Place of Death: _____
Signature of Physician: _____
Signature of Coroner: _____
Signature of Registrar: _____
Signature of Witness: _____
Signature of Burial Officer: _____
Signature of Minister: _____
Signature of Undertaker: _____
Signature of Embalmer: _____
Signature of Funeral Home: _____
Signature of Cemetery: _____
Signature of Interment: _____
Signature of Burial: _____
Signature of Burial Officer: _____
Signature of Minister: _____
Signature of Undertaker: _____
Signature of Embalmer: _____
Signature of Funeral Home: _____
Signature of Cemetery: _____
Signature of Interment: _____
Signature of Burial: _____

Attest: _____
Date: _____
Place: _____
Signature: _____
Name: _____
Age: _____
Sex: _____
Race: _____
Color: _____
Height: _____
Weight: _____
Build: _____
Complexion: _____
Eyes: _____
Hair: _____
Manner of Death: _____
Cause of Death: _____
Time of Death: _____
Place of Death: _____
Signature of Physician: _____
Signature of Coroner: _____
Signature of Registrar: _____
Signature of Witness: _____
Signature of Burial Officer: _____
Signature of Minister: _____
Signature of Undertaker: _____
Signature of Embalmer: _____
Signature of Funeral Home: _____
Signature of Cemetery: _____
Signature of Interment: _____
Signature of Burial: _____
Signature of Burial Officer: _____
Signature of Minister: _____
Signature of Undertaker: _____
Signature of Embalmer: _____
Signature of Funeral Home: _____
Signature of Cemetery: _____
Signature of Interment: _____
Signature of Burial: _____

1469 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
g. STREET ADDRESS 1 909 Cental St.,				h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Phillip Middle Garrett Last Sr.				4. DATE OF DEATH Month February Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1877	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charles P. Garrett				14. MOTHER'S MAIDEN NAME Margaret Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Phillip E. Garrett, 909 Central St. Annap.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 Carcinoma of the bladder DUE TO (b) 30 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive pulmonary disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 11, 1960 to Feb. 11, 1960 that I last saw the deceased alive on Feb. 11, 1960 and that death occurred at 12:00 Noon from the causes and on the date stated above.							
ACTUAL SIGNATURE R. L. Richardson				ADDRESS (Street, city or town, state) 110 Clay St.,			
PHYSICIAN'S NAME (Type) R. L. Richardson				DATE SIGNED 2/12/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-14-1960			
22c. NAME OF CEMETERY OR CREMATORY Adams Cemetery				22d. LOCATION (City, town, or county) (State) Bayard Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William Keese				24a. REC'D BY REGISTRAR DATE FEB 16 '60			
ADDRESS Annapolis Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

4 Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1512 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 8mo. 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Gordon Last Gordon				4. DATE OF DEATH Month 2 Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 29, 1872	
9. AGE (In years lost birthday) yrs. 87		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Charlette Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 309X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypostatic Pneumonia DUE TO (c) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 4				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
				20f. (City or town) -----		(County) (State)	
21. I certify that I attended the deceased from 5/22 , 19 59 , to 2/17 , 19 60 , that I last saw the deceased alive on 2/17 , 19 60 , and that death occurred at 5:15P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/18/60							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. Crownsville State Hospital, Md. 2/18/60			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 2/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/60		22c. NAME OF CEMETERY OR CREMATORY Chesterville Cem.		22d. LOCATION (City, town, or county) (State) nr. Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. Dist. No.

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DECEASED'S NAME

AGE

SEX

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DATE

TIME

PLACE

CAUSE

DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1513

CERTIFICATE OF DEATH

01485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
c. LENGTH OF STAY IN 1b 7 yrs.				d. STREET ADDRESS 299 Bar Harbor Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 299 Bar Harbor Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEONARD First Middle Last				4. DATE OF DEATH February Month Day Year 3 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April, 2, 1866	
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Hardware			
11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis L. Gosnell				14. MOTHER'S MAIDEN NAME Mary Lugenbeel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 4619			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				18. INFORMANT Marshall Gosnell--Baltimore 29, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Interosclerotic Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 13, 1959 to Feb. 3, 1960 that I last saw the deceased alive on Feb. 2, 1960 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin				ADDRESS (Street, city or town, state) R.F.O.B. 442 Pasadena Md. Feb. 4, 1960			
PHYSICIAN'S NAME (Type) R.M. McLaughlin				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel Cemety, Carroll Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz				24a. REC'D BY REGISTRAR DATE FEB 8 '60			
24b. REGISTRAR'S SIGNATURE Carroll Co. Md.				24c. REGISTRAR'S SIGNATURE			

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MEDICAL CERTIFICATION

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
1913 CERTIFICATE OF DEATH

NAME: ANNIE ALBON SEX: F AGE: 40 YEARS

RESIDENCE: WHEELING, W. VA.

DATE OF DEATH: NOV. 10, 1913

PLACE OF DEATH: HOME

CAUSE OF DEATH: CHLORIDE OF ARSINE

DATE OF BURIAL: NOV. 12, 1913

PLACE OF BURIAL: WHEELING, W. VA.

SIGNATURE OF PHYSICIAN: DR. J. H. HARRIS

SIGNATURE OF CORONER: W. H. HARRIS

SIGNATURE OF WITNESSES: DR. J. H. HARRIS

SIGNATURE OF DEATH REGISTRAR: W. H. HARRIS

SIGNATURE OF CLERK: W. H. HARRIS

SIGNATURE OF JURY: W. H. HARRIS

SIGNATURE OF JUDGE: W. H. HARRIS

SIGNATURE OF SHERIFF: W. H. HARRIS

SIGNATURE OF DISTRICT ATTORNEY: W. H. HARRIS

SIGNATURE OF COUNTY CLERK: W. H. HARRIS

SIGNATURE OF TOWNSHIP CLERK: W. H. HARRIS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Louis First Middle Last Gross		4. DATE OF DEATH Feb. Month 6 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (State or foreign country) Churchton Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Matilda Gross Churchton Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 220167733 INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-2-60 , 19 60 , to 2-6-60 , 19 60 , that I last saw the deceased alive on 2-5-60 , 19 60 , and that death occurred at 4:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Churchton St Churchton Md. DATE SIGNED 2-6-60 ACTUAL SIGNATURE G. T. Allen M.D. G. T. Allen PHYSICIAN'S NAME (Type) A T ALLEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 9 1960	22c. NAME OF CEMETERY OR CREMATORY Gross Cemetery	22d. LOCATION (City, town, or county) (State) Churchton Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rebecca Hardaway Lovell ADDRESS Chesapeake		24a. REC'D BY REGISTRAR FEB 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1514 CERTIFICATE OF DEATH

01487

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 40 y.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same 60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 614 1/2 N Crain Highway				d. STREET ADDRESS Same 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mammie M Hall Middle Last				4. DATE OF DEATH Month February Day 6 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/69		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Middlesex, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leroy Gibson				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Catherine Bennett, (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left leg with numerous metastases. 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) General arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years						INTERVAL BETWEEN ONSET AND DEATH 14 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 48 to February 6 1960 that (I) (we) last saw the deceased alive on January 15 1960 , and that death occurred at 3 A M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Gustave H. Faubert</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 2/7/60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.				22d. ADDRESS Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Feb 9-60		23c. NAME OF CEMETERY OR CREMATORY Glen Burnie Cemetery		23d. LOCATION (City, town, or county) (State) Glen Burnie Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James A. Zwick</i>				25a. REC'D BY REGISTRAR FEB 9 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

01137

WARRANTED BY THE MANUFACTURER OR REPAIRER
THIS UNIT IS GUARANTEED TO BE FREE FROM DEFECTS IN MATERIAL AND WORKMANSHIP FOR A PERIOD OF 90 DAYS OR 10,000 MILES, WHICHEVER COMES FIRST.

1971 CHRYSLER CRYSLER



Model Name

Chrysler

1971

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WARRANTED BY THE MANUFACTURER OR REPAIRER
THIS UNIT IS GUARANTEED TO BE FREE FROM DEFECTS IN MATERIAL AND WORKMANSHIP FOR A PERIOD OF 90 DAYS OR 10,000 MILES, WHICHEVER COMES FIRST.

1 1515 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>LAUREL</u> MARYLAND <u>CHILDRENS CENTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL, M.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DISTRICT TRAIN. School</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE (KATIE) HANLEY</u>		4. DATE OF DEATH Month Day Year <u>2 6 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-97</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL J. HANLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY M. (UNKNOWN) PRICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>— NO —</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>John J. Moore Jr</u>		Address <u>Supt D.T.S.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>570.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. DUE TO <u>Intestinal ileus</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>January 25th to February 6th</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental deficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 25, 1960</u> , to <u>February 6, 1960</u> , that I last saw the deceased alive on <u>February 5, 1960</u> , and that death occurred at <u>2:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Glass M.D.</u>		ADDRESS (Street, city or town, state) <u>276-60 DATE SIGNED</u> <u>CHILDRENS CENTER LAUREL MD.</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE GLASS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Christ. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>5801 Cleve. Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

10-10-68

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Signature of informant		14. Date of filing		15. File number	
John Doe		Male		White		10-10-68		New York, N.Y.		New York, N.Y.		10-10-68		New York, N.Y.		Heart disease		Natural		John Doe, M.D.		Jane Doe		John Doe		10-10-68		10-10-68	

1516

CERTIFICATE OF DEATH

01489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 620 Gold Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Harris Last Harris				4. DATE OF DEATH Month 2 Day 18 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900?	
9. AGE (In years last birthday) 60?		10. IF UNDER 1 YEAR Months 60? Days 60? Hours 60? Min. 60?		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c) Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month 2 Day 2 Year 1960 Hour 9:40 p. m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---				20f. (City or town) --- (County) --- (State) ---			
21. I certify that I attended the deceased from 2/2/1960 to 2/18/1960 , that I last saw the deceased alive on 2/18/1960 , and that death occurred on 2/18/1960 at 9:40P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/19/60			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				ADDRESS Crownsville State Hospital, Md. DATE SIGNED 2/19/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				24a. REC'D BY REGISTRAR DATE FEB 23 '60			
ADDRESS 1631 1/2 Dundell Hill				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1517 CERTIFICATE OF DEATH

Reg. Dist. No.

01490

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie	
c. LENGTH OF STAY IN 1b 30 YRS.		d. STREET ADDRESS Johnson Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emil Middle L. Last Hittle		4. DATE OF DEATH Month Feb. Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1907
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Owner		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Hittle		14. MOTHER'S MAIDEN NAME Alouise Uresch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-4514	
17. INFORMANT Address Mrs Anna Hittle, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PRIMARY CARCINOMA OF BLADDER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH DIAGNOSED 2 mos. Ago
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 2, 1959 to FEB 22, 1960 , that I last saw the deceased alive on FEB 18, 1960 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Barber C. Palmer		ADDRESS (Street, city or town, state) 77 FRANKLIN ST. ANNAPOLIS, MD.	
PHYSICIAN'S NAME (Type) Barber C. Palmer, M.D.		DATE SIGNED 2-22-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/60	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping + KIRKLEY, GLEN BURNIE, MD		24a. REC'D BY REGISTRAR FEB 26 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1918 CERTIFICATE OF BIRTH

11100

State of New York

30 yrs

Albion, New York

1888-1918 Mrs Anna Miller, born at 2

Metropolitan

Primary (New York)

Nov 2

Charles E. Smith

Albion, N.Y.

John Brown, Secretary, New York

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1518 CERTIFICATE OF DEATH

01491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
c. LENGTH OF STAY IN 1b <u>3yrs. 9mo. 25days</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>148 O'Berry Court</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Elizabeth</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1914</u>	9. AGE (In years lost birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Harris</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Inslly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perinephric Abscess</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pyonephrosis</u> DUE TO (c) <u>Chronic Pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> - <u>p. m.</u> - 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/19</u> , 19 <u>56</u> , to <u>2/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md. 2/14/60</u>					
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		<u>Crownsville State Hospital, Md. 2/14/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese Jr. - Annap. Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>2-17-60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

010

2

1212 CERTIFICATE OF DEATH

NAME OF DECEASED: *William Joseph*
AGE: *78*
SEX: *M*
DATE OF DEATH: *1912*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Old age*
SIGNATURE OF DECEASED: *William Joseph*
SIGNATURE OF WITNESSES: *John Doe*
SIGNATURE OF MINISTER: *John Doe*
SIGNATURE OF CLERK: *John Doe*

1 800
1519 CERTIFICATE OF DEATH

1519 CERTIFICATE OF DEATH

Reg. Dist. No.

01492

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 8mo. 26 yrs. 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennie Middle Last Howard				4. DATE OF DEATH Month 2 Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1868?	
9. AGE (In years lost birthday) 91? yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Lindsay				14. MOTHER'S MAIDEN NAME Jenny			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile Cachexia 309 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome Associated with Generalized DUE TO Arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/25 , 19 33 , to 2/5 , 1960, that I last saw the deceased alive on 2/5 , 19 60 , and that death occurred at 4:10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/8/60							
ACTUAL SIGNATURE L. Benedict, M. D.				M.D. Crownsville State Hospital, Md. 2/8/60			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 2/8/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removed		2-9-60		St. Agnes		Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Seese, Jr. - Annapolis, Md.				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE FEB 10 '60				W. Seese			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1520 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. LENGTH OF STAY IN 1b 4 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 305, RTE #1.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH M. HUBER				4. DATE OF DEATH Month Day Year FEB. 28 1960			
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1867) JAN. 2, 1867	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN MAHR				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. NONE INFORMANT MRS. LILLIAN MACK Address Box 305, RTE 1 PASADENA, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with left hemiplegia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 16, 1960 to Feb. 28, 1960 that I last saw the deceased alive on Feb. 25, 1960 , and that death occurred at 12:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmond I. Moushabeck M.D.				ADDRESS (Street, city or town, state) 2101 S. Ritchie Highway DATE SIGNED Feb. 28, 1960			
PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK, Glen Burnie, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann ADDRESS 3218 HUDSON ST.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME: ELIZABETH M. HUBER
AGE: 4 YRS
SEX: F
RACE: WHITE
MARRIAGE: SINGLE
BIRTH: 1916
DEATH: 1920
PLACE OF BIRTH: ALBANY, N.Y.
PLACE OF DEATH: ALBANY, N.Y.
CAUSE OF DEATH: INFANTILE PAROTITIS
DIAGNOSIS: INFANTILE PAROTITIS
TREATMENT: NONE
BURIAL: ALBANY, N.Y.

Signature: [Illegible]
Date: 1/10/20
Witness: [Illegible]
Registrar: [Illegible]

1521 CERTIFICATE OF DEATH

01494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 16 years 8mo. 8 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 557 W. Biddle Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Clarence Middle Hunter Last Hunter				4. DATE OF DEATH Month 2 Day 23 Year 19 60				5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1918?				9. AGE (In years last birthday) 41? yrs.				10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. 1				11. IF UNDER 24 HRS. Months 4 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer								10b. KIND OF BUSINESS OR INDUSTRY -----								11. BIRTHPLACE (State or foreign country) Virginia								12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Unknown												14. MOTHER'S MAIDEN NAME Lucindy																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. Unknown								17. INFORMANT Hospital records								Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerosis DUE TO (c) -----																								INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----																											
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. - 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----								20f. (City or town) (County) (State) -----											
21. I certify that I attended the deceased from 6/15 , 19 43 to 2/23 , 19 60 , that I last saw the deceased alive on 2/23 , 19 60 , and that death occurred at 5:05 P. M, from the causes and on the date stated above.																																			
ACTUAL SIGNATURE Hildegard Heard Reissman												M.D. Crownsville State Hospital, Md.												DATE SIGNED 2/24/60											
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.												Crownsville State Hospital, Md.												2/24/60											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb 27, 1960								22b. DATE THEREOF Feb 27, 1960								22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery								22d. LOCATION (City, town, or county) (State) Baltimore Md.											
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ												ADDRESS 2222 W. North Ave.												24a. REC'D BY REGISTRAR Feb 29 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Haines							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

591

251

1471 CERTIFICATE OF DEATH

01495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hewwood Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dr. Grace Lewis Hurd</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>See 17-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. Osteopathy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Osteopathy</u>		11. BIRTHPLACE (State or foreign country) <u>New Mexico</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Moses Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Grace Mason</u> Address <u>(2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Stomach</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>60</u> , to <u>2-9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-9</u> , 19 <u>60</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward H. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>2/10/60</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 12 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1145

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 12/14/64		15. TIME OF DEATH 10:15 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	

RECEIVED
JAN 15 1965

1
The State of Maryland, Department of Health, Baltimore, 10
This is to certify that the above is a true and correct copy of the
original record as it appears in the files of the Department of Health,
Baltimore, 10, Maryland, and that the same is a true and correct copy
of the original record as it appears in the files of the Department of Health,
Baltimore, 10, Maryland.

1472 CERTIFICATE OF DEATH

Reg. Dist. No.

01496

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Riviera Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1312 West St. Homewood-Care Home</u>				d. STREET ADDRESS <u>171 Carroll Road</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>HYNSON</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Nov. 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind. Prydack</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co., md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) HYNSON</u>				14. MOTHER'S MAIDEN NAME <u>TEMPERANCE (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mrs. Hilda Luedtke</u>		Address <u>Box 180 A - Solleys Rd Pasadena, md.</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE & CONGESTIVE FAILURE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.	Month <u></u> Day <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>59</u> , to <u>15 FEB.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>15 FEB.</u> , 19 <u>60</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Best</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u>		DATE SIGNED <u>2/16/60</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>19 Feb. 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Glen Burnie</u>		(State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie</u> ADDRESS <u>Singletons Rd</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 9mo. 46 years 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Last Johnson		4. DATE OF DEATH Month 2 Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) Approx. 80
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerry Johnson		14. MOTHER'S MAIDEN NAME Rachel Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular Fibrillation DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy and Mental Deficiency			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) -----		(County) (State)	
21. I certify that I attended the deceased from 5/13 , 19 60 , to 2/17 , 19 60 , that I last saw the deceased alive on 2/17 , 19 60 , and that death occurred at 10:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 2/18/60			
ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i>		M.D. Crownsville State Hospital, Md. 2/18/60	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 2/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial 2/20/60	2/20/60	Montgomery Co	Montgomery Co
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		24. REC'D BY REGISTRAR DATE FEB 23 1960	
ADDRESS Rockville		24b. REGISTRAR'S SIGNATURE <i>John S. Krawiec</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1473 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1 50 Fleet St.	
3. NAME OF DECEASED (Type or print) First Cora Middle Last JONES		4. DATE OF DEATH Month February Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1893
9. AGE (In years, day, yrs.) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Keals Perry		14. MOTHER'S MAIDEN NAME Amanda B. Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Willie Hall Edgewater Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X abscess of pancreas DUE TO Empyema of Gallbladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholelithiasis DUE TO Carcinoma of Stomach (c) peptic ulcer of stomach 1954			INTERVAL BETWEEN ONSET AND DEATH 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1954			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 26, 1960 , to Feb 4, 1960 , that I last saw the deceased alive on Feb 4, 1960 , and that death occurred at 11:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edith Rodler M.D.		ADDRESS (Street, city or town, state) 45 Franklin St., DATE SIGNED	
PHYSICIAN'S NAME (Type) Edith Rodler		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-7-1960	Chews Chapel	Owensville Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Reese Anna Md.		24a. REC'D BY REGISTRAR FEB 8 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Page 4

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1523

CERTIFICATE OF DEATH

01199

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A. A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold X	
d. NAME OF HOSPITAL (If not in hospital, give street address) Joyce Lane		d. STREET ADDRESS Joyce Lane	
3. NAME OF DECEASED (Type or print) First MARY Middle AMY Last JOYCE		4. DATE OF DEATH Month Feb. Day 21, Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Octavus Knight		14. MOTHER'S MAIDEN NAME Laura V. Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. J. Rodgers Joyce - Arnold, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis / Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 hr. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 1953 to Feb. 21, 1960 , that I last saw the deceased alive on Jan. 10, 1960 , and that death occurred at 4:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 SHAW ST. ANNAPOLIS, MD. DATE SIGNED 2/21/60			
ACTUAL SIGNATURE James R. Martin		M.D. 6 SHAW ST. ANNAPOLIS, MD.	
PHYSICIAN'S NAME (Type) JAMES R. MARTIN		ANNAPOLIS, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Lickner		ADDRESS Balto., Md.	
24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5B

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

IN SENATE,
January 18, 1900.

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899.

ALBANY, N. Y.:
JANUARY 18, 1900.

PRINTED BY THE
UNIVERSITY OF THE STATE OF NEW YORK

AT ALBANY, N. Y.

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THE UNIVERSITY OF THE STATE OF NEW YORK

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THE UNIVERSITY OF THE STATE OF NEW YORK

1524 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2 years 3mo. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Lee				4. DATE OF DEATH Month 2 Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June, 18th 1972	
9. AGE (In years last birthday) 87 yes		IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS. Days 27			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Lee				14. MOTHER'S MAIDEN NAME Barbara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, Terminal 794X DUE TO CACHEXIA, SENILE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ----- (c) ----- INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcerative Colitis, Chronic. Generalized Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 11/15 , 19 57 , to 2/19 , 19 60 , that I last saw the deceased alive on 2/19 , 19 60 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/19/60							
ACTUAL SIGNATURE Hildegard Heard Reigman				M.D. Crownsville State Hospital, Md. 2/19/60			
PHYSICIAN'S NAME (Type) Hildegard Heard Reigman, M. D.				Crownsville State Hospital, Md. 2/19/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-60		22c. NAME OF CEMETERY OR CREMATORY Church Creek		22d. LOCATION (City, town, or county) (State) Beardmont Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. S. Nelson				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE FEB 24 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Francis			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

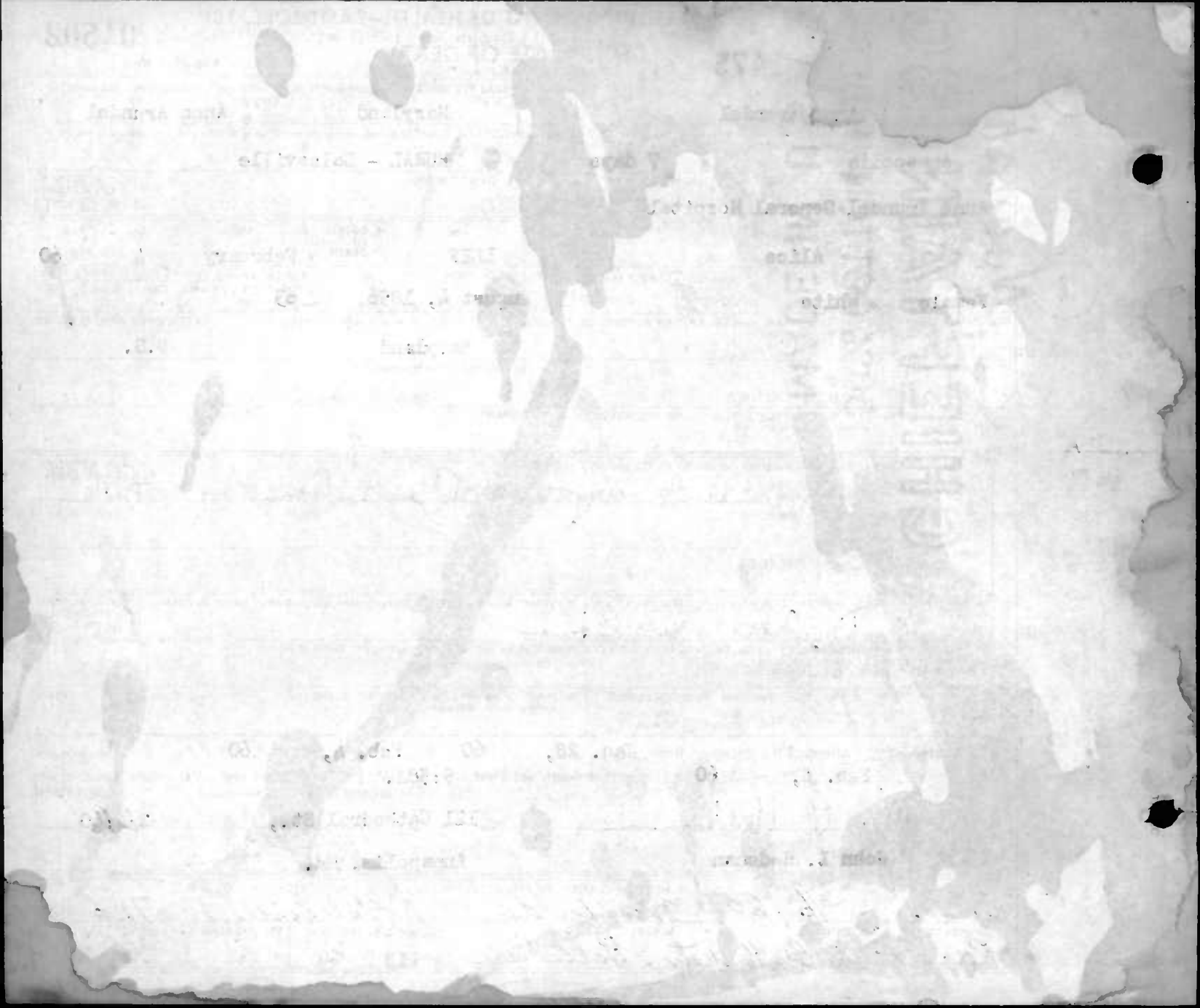
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CERTIFICATE OF DEATH

Reg. Dist. No.

01502

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Galesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Last LEEF		4. DATE OF DEATH Month February Day 4 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1896	9. AGE (In years last birthday) 61 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Bowen		14. MOTHER'S MAIDEN NAME Rosabelle Hinton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus					INTERVAL BETWEEN ONSET AND DEATH 72 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 28, 1960 , to Feb. 4, 1960 that I last saw the deceased alive on Feb. 4, 1960 , and that death occurred at 9:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md. DATE SIGNED 2/4/60					
ACTUAL SIGNATURE John L. Hedeman PHYSICIAN'S NAME (Type)		M.D. 121 Cathedral St., Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/60		22c. NAME OF CEMETERY OR CREMATORY Woodfield	
22d. LOCATION (City, town, or county) Galesville Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Q. Hardy ADDRESS Galesville		24a. REC'D BY REGISTRAR DATE FEB 8 '60		24b. REGISTRAR'S SIGNATURE Carl S. Kneass	



1525 CERTIFICATE OF DEATH

01503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green Haven Pasadena</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green Haven Pasadena, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.D. 3 BOX #467B</i>		d. STREET ADDRESS <i>1 R.F.D. BOX #467 B.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ADOLPH WILLIAM LEISNER</i>		4. DATE OF DEATH Month Day Year <i>February 5 1960</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 25 1879</i>
9. AGE (In years last birthday) <i>80 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ALFRED LEISNER</i>		14. MOTHER'S MAIDEN NAME <i>ERNESTINE ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-05-3147</i>	
17. INFORMANT Address <i>MRS. GERTRUDE KUHN Pasadena, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> DUE TO <i>Arteriosclerotic Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension</i> (b) <i>443X</i> (c) <i>4 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>2 years</i> <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October 20 1959</i> to <i>February 5 1960</i> , that I last saw the deceased alive on <i>February 3 1960</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>R.F.D. Box 442 Pasadena, Md. Feb 5, 1960</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>BURIAL</i>	<i>2-8-60</i>	<i>MT. CARMEL CEM.</i>	<i>5712 O'DONNELL ST. BALTO., MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Charles S. Gailer 901 S. CONKLING ST. BALTO., MD.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 8 '60</i>	24b. REGISTRAR'S SIGNATURE

7150

1526 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>5 Hrs 17 Min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Christopher</u> Middle <u>-</u> Last <u>Lewallen</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 February 1960</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>		11. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Elmer E. Lewallen</u>				14. MOTHER'S MAIDEN NAME <u>Marie McGirt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. INFORMANT <u>Mother</u>				Address <u>1545-C Carvel Ave, FGGM, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>21 February 1960</u> , to <u>21 February 1960</u> , that I last saw the deceased alive on <u>21 February 1960</u> , and that death occurred at <u>5:45P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>21 Feb 60</u>							
ACTUAL SIGNATURE <u>Roger C. Moyer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ROGER C. MOYER, CAPT., MC</u>				U.S. Army Hospital, Fort Geo G Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>23 Feb 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory, US Army Hospital, Fort George G. Meade, Md</u>		22d. LOCATION (City, town, or county) (State) <u>Fort George G. Meade, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty M. Ellis</u> Capt., MSC, USAH, FGGM, Md				24a. REC'D BY REGISTRAR <u>FEB 26 1960</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Knecht</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Cristal</u> Middle <u>-</u> Last <u>Lewallen</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 February 60</u>
9. AGE (In years last birthday) yrs. <u>762.5</u>		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Elmer E. Lewallen</u>	14. MOTHER'S MAIDEN NAME <u>Marie McGirt</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>	16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	INFORMANT <u>Mother</u>	Address <u>Ft Geo G Meade, Md</u> <u>1545-C Carvel Ave.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Atelectasis</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Since Birth</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(County) (State)</u>

21. I certify that I attended the deceased from 22 February, 1960, to 22 February, 1960, that I last saw the deceased alive on 22 February, 1960, and that death occurred at 7:20 A, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE <u>Wilbur H. Miller</u> M.D.	PHYSICIAN'S NAME (Type) <u>WILBUR H. MILLER, JR., CAPT., MC US Army Hospital, Fort Geo G Meade, Md</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>23 Feb 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory, US Army Hospital, Fort George G. Meade, Md</u>	22d. LOCATION (City, town, or county) (State) <u>(County) (State)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty M. Ellis</u> Capt., MSC, USAH, FGM		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2250225XVI

1882

1882

CERTIFICATE OF DEATH

Name of Deceased: [illegible]

Age: [illegible]

Sex: [illegible]

Place of Birth: [illegible]

Date of Death: [illegible]

Time of Death: [illegible]

Place of Death: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Burial Officer: [illegible]

Signature of Minister: [illegible]

Signature of Undertaker: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1476 CERTIFICATE OF DEATH

Reg. Dist. No.

01506

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				d. STREET ADDRESS 321 N. Glenn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Oscar W. LINDAUER				4. DATE OF DEATH Month Day Year 2 13 60			
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-07		9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY MILITARY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benson DePaul Lindauer				14. MOTHER'S MAIDEN NAME Mary E. Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wife: Eleanor H. Lindauer 321 N. Glenn Ave. Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease With Angina Pectoris DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate 5 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Feb 1960 , to 13 Feb 1960 , that I last saw the deceased alive on Never , 19 60 , and that death occurred at 11:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND ACTUAL SIGNATURE Lybair Busch M.D. PHYSICIAN'S NAME (Type) S. (n) BUSCH LT MC USNR U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sins				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR Feb 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1528

CERTIFICATE OF DEATH

Reg. Dist. No.

01507

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3mo. 23 yrs 10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>551 S. Paca Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Logan</u> Last <u>Logan</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 5, 1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Degeneration</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Chronic Undifferentiated Type</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>10/19</u> , 19 <u>36</u> , to <u>2/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/9</u> , 19 <u>60</u> , and that death occurred at <u>1:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>2/9/60</u>			
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				Crownsville State Hospital, Md. <u>2/9/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u> </u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Choy O. Wilson</u>				ADDRESS <u>1000 Brantley Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. L. K...</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1477 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen'l Hosp.</u>				d. STREET ADDRESS <u>Cresston Park</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 July 1874</u>	9. AGE (In years last birthday) <u>85 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Long</u>				14. MOTHER'S MAIDEN NAME <u>Margaret A. Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>48 S. Fulton</u> <u>Baltimore 23, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive gas, haematemesis, hemorrhage,</u> <u>578x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>site not determined at autopsy</u> DUE TO (c) <u>4 da.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tubercle Pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>2/2</u> , 19 <u>60</u> , to <u>2/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/12</u> , 19 <u>60</u> , and that death occurred at <u>6:23 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Reeler</u> M.D.				ADDRESS (Street, city or town, state) <u>121 CATAWBA ST</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. REELER</u>				DATE SIGNED <u>2/13/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>16 Feb '60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u> ADDRESS <u>Steen Burn</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05209

CERTIFICATE OF DEATH

1928

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored and difficult to read.]

CERTIFICATE OF DEATH

Reg. Dist. No.

01510

1530

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> 02 X 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>			d. STREET ADDRESS <u>1550-B</u>		
3. NAME OF DECEASED (Type or print) First <u>Belinda</u> Middle <u>K.</u> Last <u>Malugin</u>			4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 August 1959</u>		9. AGE (In years lost birthday) yrs. <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	11. BIRTHPLACE (State or foreign country) <u>Columbia, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Robert J. Malugin</u>			14. MOTHER'S MAIDEN NAME <u>Bessie Vance</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>	INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus - Dehydration</u> 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 February, 1960</u> , to <u>27 February, 1960</u> , that I last saw the deceased alive on <u>27 February, 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Joseph R. Rokous</u>			ADDRESS (Street, city or town, state) DATE SIGNED <u>27 Feb 60</u>		
PHYSICIAN'S NAME (Type) <u>JOSEPH R. ROKOUS, CAPT., MC</u>			U.S. Army Hospital, Ft Geo G. Meade, Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 March 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belmont Grove</u>	
22d. LOCATION (City, town, or county) (State) <u>Mt. Pleasant, Tennessee</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '60</u>	
		ADDRESS <u>Shenandoah, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraso</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1933

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Handwritten signature

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 3 FilmG259 3-30-60 et

01511

1478
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Annapolis</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Annapolis</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Boulevard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> Baltimore 22, Md. TOWN STREET ADDRESS <u>1312 West Street</u>	
3. NAME OF DECEASED (First) <u>Joseph</u> (Middle) <u>Marizousker</u> (Last) SEX <u>M</u> COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u> 8. DATE OF BIRTH <u>1884</u> 9. AGE last birthday <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>Feb 28</u> 19 <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Guburum</u>		14. MOTHER'S MAIDEN NAME <u>Guburum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT & ADDRESS <u>Records</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 491X IMMEDIATE CAUSE (A) <u>BROCKHO PNEUMONIA</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC PULMONARY FIBROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>23 FEB, 1960</u> , to <u>28 FEB, 1960</u> , that I last saw the deceased alive on <u>27 FEB, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward Beck</u> M.D. <u>41 Southgate Ave Annapolis</u> DATE SIGNED <u>4/28/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>Mar 1/60</u> NAME OF CEMETERY OR CREMATORY <u>St Peter Cemetery</u> LOCATION (City, town, or county) <u>Rockledge St. Md</u> (State)			
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>John W. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. ...</u> ADDRESS <u>637 West 130 St Baltimore, Md.</u>	

DATE MAR 2 '60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1531 CERTIFICATE OF DEATH

Reg. Dist. No.

01512

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Rene Ave.				d. STREET ADDRESS 22 Rene Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Victorine Tobie Mayer				4. DATE OF DEATH Month Day Year February 24, 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1892	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT George F. Mayer Address 22 Rene Ave. Balto. 25, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Biliary dyskinesia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 9	Day 9	Year 19 60	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Balto. 25, Anne Arundel Co., Md.	
21. I certify that I attended the deceased from 9/9, 19 59 , to 2/24, 19 60 , that I last saw the deceased alive on 2/24, 19 60 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5010A Gov. Ritchie Hwy. Feb. 25, 1960							
ACTUAL SIGNATURE Morton M. Krieger			M.D. 5010A Gov. Ritchie Hwy. Feb. 25, 1960				
PHYSICIAN'S NAME (Type) Morton M. Krieger			Balto. 25, Anne Arundel Co., Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 27, 1960	22c. NAME OF CEMETERY OR CREMATORY E. Wildwood Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Pennsylvania			
23. FUNERAL DIRECTOR'S SIGNATURE George F. Mayer			ADDRESS 4001 Ritchie Hwy. Balto. 25		24a. REC'D BY REGISTRAR 1 MAR 1 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1931"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF BIRTH [Faint text, possibly "New York"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARRIAGE [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]	
RELIGION [Faint text, possibly "Catholic"]		SERVICE [Faint text, possibly "None"]	
PREVIOUS ILLNESS [Faint text, possibly "None"]		MEDICAL ATTENDANCE [Faint text, possibly "None"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]	
SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]	

This certificate is to be filled out by the physician or coroner in charge of the death. It should be filled out as soon as possible after the death, and should be filed in the office of the State Department of Health. The certificate should be filled out in duplicate, and the original should be filed in the office of the State Department of Health, and the duplicate should be filed in the office of the local health officer.

1479

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle MAYNARD Last MAYNARD		4. DATE OF DEATH Month February Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1909
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Maynard		14. MOTHER'S MAIDEN NAME Haisy Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-3069	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema (marked) 334X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriolosclerosis (b) Arteriolosclerosis (c) Arteriolosclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20, 1960 , to Feb. 9, 1960 , that I last saw the deceased alive on Feb. 9, 1960 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) R. L. Richardson		DATE SIGNED 9/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		24a. REC'D BY REGISTRAR FEB 16 '60	
ADDRESS Annapolis Md		24b. REGISTRAR'S SIGNATURE Arthur S. House	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1478
CERTIFICATE OF DEATH

57-41 - Annapolis

4-25-55

1901-1902

1901-1902

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(Faint handwritten text)

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CERTIFICATE OF DEATH

Reg. Dist. No.

01514

1480

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roderick Middle S. Last MERRICK		4. DATE OF DEATH Month February Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSOR RET. USN. ACADEMY		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FREDERICK MERRICK		14. MOTHER'S MAIDEN NAME EMMA KEYES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) INFORMANT Libbiana MERRICK #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intentional obstruction 561.0 DUE TO 1. Inguinal hernia incarcerated Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. loop of ileum DUE TO (c) loop of ileum			INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia from BPH - arteriosclerotic CVD			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 , 19 Feb. 10, 1960 , that I last saw the deceased alive on Feb. 10, 1960 , and that death occurred at 3:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Shipley		ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md. DATE SIGNED 2-12-60	
PHYSICIAN'S NAME (Type) Frank M. Shipley		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	2-13-60	HILLCREST	ANNAPOLIS MD
23. FUNERAL DIRECTOR'S SIGNATURE J. M. [Signature]		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH, 18
Items, 9, 22a, 22b, 22c, 22d Film G259, 3/18/60 1b
1533 CERTIFICATE OF DEATH

01516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>13 years</u>		3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownville State Hospital</u>		d. STREET ADDRESS <u>1813 Madison Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER S. MYERS</u>		4. DATE OF DEATH <u>FEBRUARY 27 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/1914</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>	
11. BIRTHPLACE (State or foreign country) <u>CHICAGO, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>MOTTIS RICHARDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>360X Bronchopneumonia</u> DUE TO (b) <u>Dehydration and Malnutrition</u> DUE TO (c) <u>Diabetes Mellitus and Mental illness</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated to Convulsive Disorder</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 16 1947</u> to <u>February 27 1960</u> that I last saw the deceased alive on <u>February 27 1960</u> and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Enrique J. del Campo</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>Feb 27/1960</u>	
PHYSICIAN'S NAME (Type) <u>Enrique J. del Campo</u>		<u>Crownsville Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>3/2/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Cooper Sr</u>		ADDRESS <u>512 Carrollton Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-10

CERTIFICATE OF DEATH

1933

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible fragments include:]

NAME: ...
AGE: ...
SEX: ...
DATE OF BIRTH: ...
PLACE OF BIRTH: ...
DATE OF DEATH: ...
PLACE OF DEATH: ...
CAUSE OF DEATH: ...
SIGNATURE: ...
DATE: ...

1601 CERTIFICATE OF DEATH

NAME - [illegible]
AGE - [illegible]
SEX - [illegible]
RACE - [illegible]

DATE OF DEATH - [illegible]

PLACE OF DEATH - [illegible]

NAME OF PHYSICIAN - [illegible]

DATE - [illegible]

TIME - [illegible]

LOCATION - [illegible]

BY [illegible]

DATE - [illegible]

TIME - [illegible]

LOCATION - [illegible]

NAME - [illegible]

DATE - [illegible]

1601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1534

CERTIFICATE OF DEATH

01518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANOVER Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HANOVER Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd.</u>		d. STREET ADDRESS <u>Ridge Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MADA V. PARKS</u>		4. DATE OF DEATH Month Day Year <u>Feb. 14, 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/1911</u>
9. AGE (In years last birthday) yrs. <u>48</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DALFUS H. Jesse</u>		14. MOTHER'S MAIDEN NAME <u>BELLIN PUCKERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. EDGAR L. PARKS</u>		Address <u>Ridge Rd. HANOVER, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Ovarian Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u> <u>1 YR-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>59</u> , to <u>2-14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>60</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ELICOTT CITY</u> DATE SIGNED <u>2-15-60</u>			
ACTUAL SIGNATURE <u>P. V. Thorpe</u> M.D.			
PHYSICIAN'S NAME (Type) <u>PETER V. THORPE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/17/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Tramm Schuch</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1535

CERTIFICATE OF DEATH

01519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>River Road</u>				d. STREET ADDRESS <u>River Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle <u>S</u> Last <u>PEDDICORD</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Stouter</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Esther E. Fowler- Daughter- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>31 MO</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>60</u> , to <u>Feb 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>60</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward G Skerritt</u> M.D.				ADDRESS (Street, city or town, state) <u>Gambrells Md</u>		DATE SIGNED <u>2-23-60</u>	
PHYSICIAN'S NAME (Type) <u>Edward Skerritt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

482 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Steuart Level		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle EVANS Last PHIPPS				4. DATE OF DEATH Month February Day 24 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3 1888		9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTY ROAD EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE		11. BIRTHPLACE (State or foreign country) Maryland Churchton		12. CITIZEN OF WHAT COUNTRY? U.S..	
13. FATHER'S NAME Andrew Phipps				14. MOTHER'S MAIDEN NAME MARY EVANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218 240364		17. INFORMANT Address MRS. ELIZABETH E. Howes, Churchton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 10, 1960 , to Feb. 24, 1960 , that I last saw the deceased alive on Feb. 24, 1960 , and that death occurred at 8:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard N. Peeler M.D.				ADDRESS (Street, city or town, state) 121 Cathedral St.,		DATE SIGNED 2/25/60	
PHYSICIAN'S NAME (Type) Richard N. Peeler				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/28/60		22c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery		22d. LOCATION (City, town, or county) (State) Kylesville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard H. Hesterly ADDRESS Salisbury				24a. REC'D BY REGISTRAR DATE FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 1536 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN 1b <u>23 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 103 Route 1</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Cora Columbia Purinton</u> First Middle Last				4. DATE OF DEATH Month <u>February</u> Day <u>3rd.</u> Year <u>19 60</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/28/76</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Cunningham</u>								14. MOTHER'S MAIDEN NAME <u>?</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs. Margaret Purinton (daughter in law).</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute virus infection</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/4/60</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>FEB. 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>								ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

01252

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. PRESENT RESIDENCE [REDACTED]	
9. DATE OF DEATH [REDACTED]		10. TIME OF DEATH [REDACTED]	
11. CAUSE OF DEATH [REDACTED]		12. MANNER OF DEATH [REDACTED]	
13. SIGNATURE OF MEDICAL EXAMINER [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF CORONER [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF DEPUTY CLERK [REDACTED]		18. SIGNATURE OF CLERK [REDACTED]	
19. SIGNATURE OF ASSISTANT CLERK [REDACTED]		20. SIGNATURE OF RECORDER [REDACTED]	
21. SIGNATURE OF INDEXER [REDACTED]		22. SIGNATURE OF FILE CLERK [REDACTED]	
23. SIGNATURE OF DISTRIBUTION CLERK [REDACTED]		24. SIGNATURE OF ARCHIVIST [REDACTED]	
25. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		26. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
27. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		28. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
29. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		30. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
31. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		32. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
33. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		34. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
35. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		36. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
37. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		38. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
39. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		40. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
41. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		42. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
43. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		44. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
45. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		46. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
47. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		48. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
49. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		50. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
51. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		52. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
53. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		54. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
55. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		56. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
57. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		58. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
59. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		60. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
61. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		62. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
63. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		64. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
65. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		66. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
67. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		68. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
69. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		70. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
71. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		72. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
73. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		74. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
75. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		76. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
77. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		78. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
79. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		80. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
81. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		82. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
83. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		84. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
85. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		86. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
87. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		88. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
89. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		90. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
91. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		92. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
93. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		94. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	
95. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]		96. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]	
97. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]		98. SIGNATURE OF ASSISTANT FILE CLERK [REDACTED]	
99. SIGNATURE OF ASSISTANT DISTRIBUTION CLERK [REDACTED]		100. SIGNATURE OF ASSISTANT ARCHIVIST [REDACTED]	

CERTIFICATE OF DEATH

Reg. Dist. No.

01523

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>311 Adams St.</i>		d. STREET ADDRESS <i>1311 Adams</i>	
3. NAME OF DECEASED (Type or print) <i>Lena H. Pamer</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>17</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 24 1887</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>aa Co md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>John Hanson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Martin L. Uhler</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Dillaber's Bldg Heart</i> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchial Asthma</i> DUE TO (c) <i>1940</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1940</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1940</i> , 19 <i>1960-2/17/60</i> , that I last saw the deceased alive on <i>2/17/60</i> , and that death occurred at <i>3:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Albert L. Anderson</i>		DATE SIGNED <i>44 Southgate Rd - Annapolis, Md - 2/17/60</i>	
PHYSICIAN'S NAME (Type) <i>ALBERT L. ANDERSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-20-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayles Son</i>		24a. REC'D BY REGISTRAR <i>Feb 23 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1484 CERTIFICATE OF DEATH

Reg. Dist. No. **01524**

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 S. Cherry Grove Ave				d. STREET ADDRESS 4 S. Cherry Grove Ave			
3. NAME OF DECEASED (Type or print) Lillian S. Rawlings				4. DATE OF DEATH 2 20 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21st 1898	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR: Months 6 Days 10 Hours 15		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) AA Co Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas Sears			
14. MOTHER'S MAIDEN NAME Ida King				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. -				17. INFORMANT Frank J. Rawlings Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Breast & Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) tortic DUE TO (c) 4 yr.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 2-20-1960 to 2-22-60 , that I last saw the deceased alive on 2-19-60 , and that death occurred at 7 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M. Shipley				DATE SIGNED 2-22-60			
PHYSICIAN'S NAME (Type) Frank M. Shipley				ADDRESS (Street, city or town, state) Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR FEB 24 1960	
				24b. REGISTRAR'S SIGNATURE J. S. [illegible]			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

877

1537

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b 1 Mo. 6 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. H. Hines Home				d. STREET ADDRESS 1508 E Street S. E.			
3. NAME OF DECEASED (Type or print) Leslie B. Rayford				4. DATE OF DEATH Month Feb. Day 17 Year 1960			
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham B. Burton				14. MOTHER'S MAIDEN NAME Catherine Couch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT John E. Rayford		Address Washington DC -1508 E.St. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 442X DUE TO Uremia (acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis (c) Cardiovascular Renal Disease						INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 day 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/13 , 19 60 , to 2/17 , 19 60 , that I last saw the deceased alive on 2/17/60 , 19 60 , and that death occurred at 5:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE DR. JOSEPH LIPSKEY		M.D.		ADDRESS (Street, city or town, state) Odenton, Md		DATE SIGNED 2/17/60	
PHYSICIAN'S NAME (Type) ODENTON, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR FEB 19 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1537

1537
CENTRAL AVE. OF DEATH

John A. Arnold

1-Mo. 6-65. Washington

1508 2nd Ave. S. E.

1508 2nd Ave. S. E.

Virginia

Catherine Gordon

Andrew S. Gordon

John E. Rayford - 1508 2nd Ave. S. E.

no name

Chief 2nd Ave. 1508 2nd Ave. S. E. 1508 2nd Ave. S. E.

The S. M. Stone Co. Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1538 CERTIFICATE OF DEATH

Reg. Dist. No.

01528

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ARUNDEL Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT 1		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOX 309 A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVELYN Middle (EVELINE) Last ROBINSON		4. DATE OF DEATH Month Feb. Day 28 Year 1960	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 25, 1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 7	11. IF UNDER 24 HRS. Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) EASTERN SHORE Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MANSHIP HOLMES		14. MOTHER'S MAIDEN NAME HARRIET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MAGGIE BESSICK		Address SEVERN Md. RT 1 Box 309A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 26, 1960 to Feb. 28, 1960 , that I last saw the deceased alive on Feb. 26, 1960 , and that death occurred at 9:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmond J. Moushabeck		ADDRESS (Street, city or town, state) 21015 Ritchie Highway	
PHYSICIAN'S NAME (Type) EDMOND J. MOUSHABEK		DATE Feb. 28, 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-2-60	22c. NAME OF CEMETERY OR CREMATORY MOUNT CALVARY CEM	22d. LOCATION (City, town, or county) (State) ARUNDEL Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE ISA:AH L. BROWN & SON		ADDRESS BALTO 30 MI. 108 W. MONTGOMERY ST	
24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Carling L. Hines	



IN THE CITY OF

STATE OF

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IN THE CITY OF

STATE OF

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IN THE CITY OF

STATE OF

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1533

CERTIFICATE OF DEATH

Reg. Dist. No.

01527

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin E. (Sanders) Middle Saunders Last Saunders				4. DATE OF DEATH Month February Day 14 , Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Owens Mills, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Annie Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1892 - 1897		17. INFORMANT Plaza Manor Convalescent Home - Glen Burnie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardio-vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 443X DUE TO (c) Many yrs.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized hypertrophic arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11, 1960 , to Feb. 14, 1960 , that I last saw the deceased alive on Feb. 12, 1960 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Pair M.D.				ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue			
PHYSICIAN'S NAME (Type) James M. Pair, M.D.				DATE SIGNED Feb. 15, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Law ADDRESS 802 Madison Ave., Balto., Md.				24a. REC'D BY REGISTRAR FEB 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1233 - CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED John Doe		DATE OF BIRTH 1-1-1900		SEX Male	
MARRIAGE Married		DATE OF MARRIAGE 1-1-1920		PLACE OF MARRIAGE Baltimore, Maryland	
PLACE OF BIRTH Baltimore, Maryland		DATE OF DEATH 1-1-1950		PLACE OF DEATH Baltimore, Maryland	
OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
EDUCATION High School		RELIGION Roman Catholic		RACE White	
MILITARY SERVICE None		PREVIOUS ILLNESS None		HISTORY OF DRUGS None	
FAMILY HISTORY None		SOCIAL HISTORY None		HISTORICAL RECORD None	
SIGNATURE OF PHYSICIAN John Doe, M.D.		DATE 1-1-1950		PLACE Baltimore, Maryland	
SIGNATURE OF REGISTRAR John Doe		DATE 1-1-1950		PLACE Baltimore, Maryland	

1540 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Georgia b. COUNTY Bleckley Maryland/ Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Cochran 49X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital						d. STREET ADDRESS Box 164 Route #1 Rt. #2					
3. NAME OF DECEASED (Type or print) First Infant Middle Last SKIPPER						4. DATE OF DEATH Month February Day 16 Year 19 60					
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Feb 60		9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wendell C Skipper						14. MOTHER'S MAIDEN NAME Ellen J Godfrey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -		INFORMANT (F) Wendell C Skipper Address Box 164 Route # 1 Laurel, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Marked prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 16 Feb , 19 60 , to 1755 hrs , that I last saw the deceased alive on 19 , and that death occurred at 1755 hrs from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 16 Feb 60 ACTUAL SIGNATURE C. Richard G. Gilbert M.D. U. S. ARMY HOSPITAL Ft Geo G Meade, Maryland PHYSICIAN'S NAME (Type) C. RICHARD GILBERT, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 17 Feb 1960		22c. NAME OF CEMETERY OR CREMATORY Laboratory, US Army Hospital, Fort George G. Meade, Md				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Betty M. Ellis Capt., MSC, USAH FtGGM						24a. REC'D BY REGISTRAR FEB 25 60		24b. REGISTRAR'S SIGNATURE Betty M. Ellis			

Name of Deceased		Date of Birth	
Sex		Race	
Usual Residence		Place of Birth	
Cause of Death		Date of Death	
Place of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Signature of Informant		Signature of Witness	
Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Cemetery	
Signature of Funeral Home		Signature of Undertaker	
Signature of Minister		Signature of Priest	
Signature of Rabbi		Signature of Imam	
Signature of Other		Signature of Other	

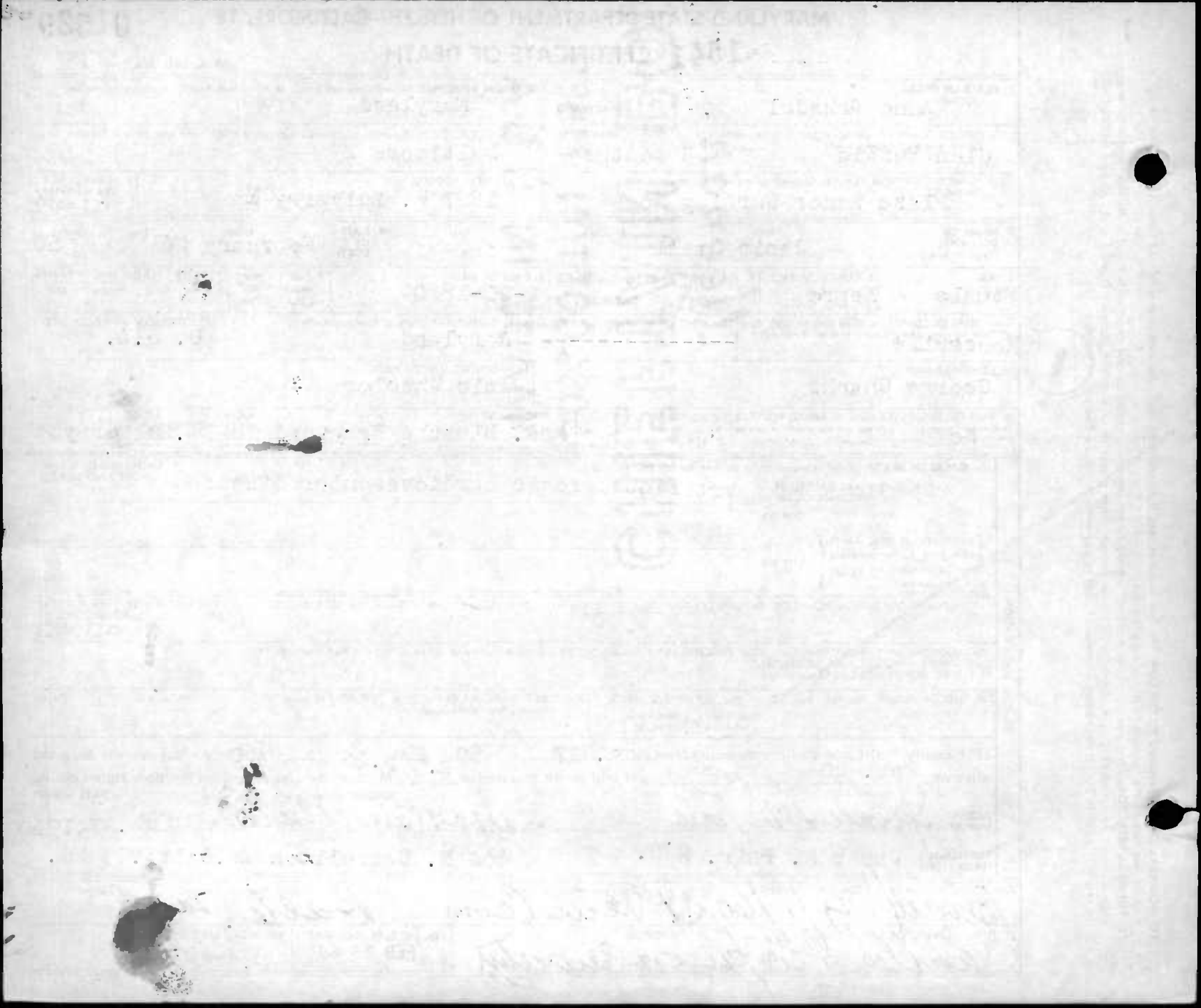
1541 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore 23</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Small</u> Last <u>Small</u>	
4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1880</u>		9. AGE (In years last birthday) <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Shanks</u>		14. MOTHER'S MAIDEN NAME <u>Janie Wheeler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mrs. Blanche Branford 1827 W. Mulberry St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Nov. 27</u> , 19 <u>59</u> , to <u>Feb. 26</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>60</u> , and that death occurred at <u>-----</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Pair</u>		ADDRESS (Street, city or town, state) <u>400 N. Carrollton Av. Balto. 23 Md.</u>			
PHYSICIAN'S NAME (Type) <u>James M. Pair. M.D.</u>		DATE SIGNED <u>Feb. 27, 1960</u>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>3/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	
22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Forster</u>		ADDRESS <u>512 Carrollton</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1485 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle SMITH Last SMITH		4. DATE OF DEATH Month February Day 15, Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min.	11. IF UNDER 24 HRS. Months 36 Days 36 Hours 36 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Moses Smith		14. MOTHER'S MAIDEN NAME Margaret Bias	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Jessie B. Smith 6 Dorsey Ave.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Diabetes Mellitus DUE TO (c) Polypoidal glomerular arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 5, 19 59 , to Feb. 15, 19 60 , that I last saw the deceased alive on Feb. 15, 19 60 , and that death occurred at 5:04 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert L. Anderson		ADDRESS (Street, city or town, state) 44 Southgate Ave., Annapolis, Md.	
PHYSICIAN'S NAME (Type) Albert L. Anderson		DATE SIGNED 2-16-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-19-1960	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Reesett		24a. REC'D BY REGISTRAR FEB 17 '60	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11500

STATE OF NEW YORK DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1934

Decedent's Name: [illegible]
Age: [illegible] Sex: [illegible]
Race: [illegible] Birth Date: [illegible]
Place of Birth: [illegible]

Place of Death: [illegible]
Cause of Death: [illegible]
Immediate Cause: [illegible]
Underlying Cause: [illegible]

Medical History: [illegible]
Occupation: [illegible]
Habits: [illegible]
Manner of Death: [illegible]
Signature of Physician: [illegible]
Signature of Registrar: [illegible]

Date of Death: [illegible]
Time of Death: [illegible]
Place of Burial: [illegible]
Signature of Burial Officer: [illegible]
Official Seal: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Last SMITH		4. DATE OF DEATH Month February Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Moses Smith		14. MOTHER'S MAIDEN NAME Opheelia Wapish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. INFORMANT Ellen Smith 88 Clay St. Annapolis Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congestive Heart Failure DUE TO Arterio-sclerotic Hypertension & Coronary Artery Disease			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 13, 1960 , to Feb. 19, 1960 , that I last saw the deceased alive on Feb. 19, 1960 , and that death occurred at 7:25A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) R. L. Richardson		DATE SIGNED 2/20/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-23-1960	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		24a. REC'D BY REGISTRAR DATE FEB 25 '60	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

1980

DATE OF DEATH

1980

PLACE OF DEATH

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1542 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>2501 Dorsey Road</u>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>H.</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 Feb 1891</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Alfred M. Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-22-0525</u>		INFORMANT <u>Son (Carl H. Stewart, Jr)</u>		Address <u>612 Evesham Ave Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1 February, 1960</u> , to <u>2 February, 1960</u> , that I last saw the deceased alive on <u>2 February, 1960</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon E Kassel</u> M.D.				DATE SIGNED <u>2 Feb 60</u>			
PHYSICIAN'S NAME (Type) <u>LEON E. KASSEL, MD</u>				<u>US Army Hospital, Fort Geo G. Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5 Feb. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto-Walk Cem.</u>		22d. LOCATION (City, town, or county) <u>Balto</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1942 CERTIFICATE OF DEATH

Full Name of Deceased: [Illegible]
Date of Birth: [Illegible]
Sex: [Illegible]
Race: [Illegible]
Date of Death: [Illegible]
Place of Death: [Illegible]
Cause of Death: [Illegible]
Occupation: [Illegible]
Signature of Registrar: [Illegible]
Date of Registration: [Illegible]

1487 CERTIFICATE OF DEATH

Reg. Dist. No.

01533

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minne Middle Gertrude Last Taylor				4. DATE OF DEATH Month February Day 18 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 89	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Singleton Taylor				14. MOTHER'S MAIDEN NAME Dorcas Adelia Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address H. Taylor Montgomery Bay Ridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410x Congestive heart failure DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 30 days 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22, 1959 , to Feb. 17, 1960 , that I last saw the deceased alive on Feb. 17, 1960 , and that death occurred at 5:35AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Hedeman M.D.				ADDRESS (Street, city or town, state) 121 Cathedral St.,		DATE SIGNED 2/18/60	
PHYSICIAN'S NAME (Type) Dr. John Hedeman				Cathedral St., Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/60		22c. NAME OF CEMETERY OR CREMATORY Short Hill Cemetery		22d. LOCATION (City, town, or county) (State) Short Hill Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE Carlton L. Kneale			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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1488 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 123 Prince George St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle F. Last TAYLOR		4. DATE OF DEATH Month February Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN R. FOUCHE		14. MOTHER'S MAIDEN NAME ANNIE R. MEDFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOHN R. TAYLOR		Address 164 Williams St. Annapolis Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal pneumonia DUE TO (c) Metastatic carcinoma both breasts PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to Feb. 6 , 19 60 , that I last saw the deceased alive on Feb. 6 , 19 60 , and that death occurred at 1:18 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., DATE SIGNED 2/8/60 ACTUAL SIGNATURE Jesse L. Wilkins M.D. PHYSICIAN'S NAME (Type) Jesse L. Wilkins Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		24a. REC'D BY REGISTRAR FEB 12 '60	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VETERANS AFFAIRS

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CERTIFICATE OF DEATH

01535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Washington Tayman				4. DATE OF DEATH Month Day Year February 5, 19 60.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Henry Tayman				14. MOTHER'S MAIDEN NAME Alice Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		INFORMANT Address Mrs. Ida May Tayman- Bristol, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar Artery Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis generalized severe DUE TO (c) 15 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Feb 2 19 60 , to 5 Feb 19 60 , that I last saw the deceased alive on 5 Feb 19 60 , and that death occurred at 9:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 2/5/60							
ACTUAL SIGNATURE Robert B. Sasscer M.D.		DATE SIGNED 2/5/60					
PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/8/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-		ADDRESS Upper Marlboro, Md.	24a. REC'D BY REGISTRAR DATE FEB 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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July 2, 1943

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01536

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Wilksontown</u>		c. LENGTH OF STAY IN 1b <u>67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u>		4. DATE OF DEATH <u>Feb 27 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
13. FATHER'S NAME <u>Nathanial Shorter</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lillian Wallace</u>		Address <u>Wilksontown md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause lost. DUE TO (c) <u>5 yr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Flu</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr Henry A. Wise Jr.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Henry A. Wise, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Faulks</u>		22d. LOCATION (City, town, or county) (State) <u>Wilksontown md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>MAR 8 '60</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01538

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

124

FOR STATE
HEALTH BUREAU

DATE OF DEATH
1944

TIME OF DEATH
12:00

PLACE OF
DEATH
HOME

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

MODE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G258, 3/16/60lb CERTIFICATE OF DEATH

Reg. Dist. No.

01537

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 1545 <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Lee</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>11½ hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>S.</u> Last <u>WAMPLER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 June 1889</u>
9. AGE (In years last birthday) <u>70 7/11</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chadwell Slomp</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
INFORMANT <u>Virginia Boatright (Dau)</u>		Address <u>5 Duval St. Odenton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hrs 30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 February, 1960</u> to <u>26 February, 1960</u> , that I last saw the deceased alive on <u>26 February, 1960</u> , and that death occurred at <u>11:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>26 Feb 60</u>			
ACTUAL SIGNATURE <u>Stanley Siegelman</u> M.D.		PHYSICIAN'S NAME (Type) <u>STANLEY SIEGELMAN, CAPT., MC</u> <u>U.S. Army Hospital, Fort Geo G Meade, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>29th. Feb. 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Big Stone Gap, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Sigler</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

U-283

1242



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Ad. Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. Ad.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Watts</u> Middle <u>Watts</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1878</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Watts</u>		14. MOTHER'S MAIDEN NAME <u>Louise Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mamie Turner Edgewater Md</u>	
17. INFORMANT <u>Mamie Turner</u> Address <u>Edgewater Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Lesion</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Shrock</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chew's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Unsame</u>		24a. REC'D BY REGISTRAR <u>C. L. King</u> 24b. REGISTRAR'S SIGNATURE <u>C. L. King</u>	
DATE <u>FEB 25 '60</u>			

[Faint, illegible text visible through the paper]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>			c. LENGTH OF STAY IN 1b <u>All Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Freetown</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sharron Watts</u>				4. DATE OF DEATH Month <u>February</u> Day <u>13th</u> Year <u>19 60</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/14/59</u>	
9. AGE (In years last birthday) <u>2</u> yrs. <u>29</u> Months <u>2</u> Days <u>29</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Sherman Watts</u>			
14. MOTHER'S MAIDEN NAME <u>Vanida Baker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>The Parents. S. WATTS, PASADENA, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/13/60</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION METHODIST MAGOTHY, MARYLAND</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM A. JACKSON INC. 916 PENN</u>				ADDRESS <u>2039 24th Ave.</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1489

CERTIFICATE OF DEATH

Reg. Dist. No.

01540

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Arnold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Rt-2, Box-279A			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Maude Middle V. Last WHITTINGTON				4. DATE OF DEATH Month February Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR 23, 1891	
				9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph Frantum				14. MOTHER'S MAIDEN NAME Sarah E. Sewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mildred V. King (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertension + arteriosclerosis DUE TO (c) Coronary Artery Disease							INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 2 gm
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November , 19 57 , to Feb. 24 , 19 60 , that I last saw the deceased alive on Feb. 24 , 19 60 , and that death occurred at 12:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard N. Peeler M.D.				ADDRESS (Street, city or town, state) 121 Cathedral St.,		DATE SIGNED 2/25/60	
PHYSICIAN'S NAME (Type) Richard N. Peeler				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		22d. LOCATION (City, town, or county) (State) Glen Burnie Md	
23. FUNERAL DIRECTOR'S SIGNATURE Gail M. Taylor				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE FEB 29 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1492

Item 2b, c & d Film 4258 3/11/60 iwk

CERTIFICATE OF DEATH

Item 1, Film 4261 4/26/60 iwk

01541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park 1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Emerson Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>41 Emerson Rd (Pvt. home)</u>		d. STREET ADDRESS <u>Severna Park, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Emelia Elizabeth Wilson</u>		4. DATE OF DEATH <u>Feb. 3 - 60</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 25, 1890</u> 1890
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William G. Shumacher</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>240</u>		17. INFORMANT <u>Herbert L. Hershman</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen. arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19____, to <u>1960</u> , 19____, that I last saw the deceased alive on <u>2-3-60</u> , 19____, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2.6.60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harwell Trace md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Cook</u>		24. REC'D BY REGISTRAR <u>Arthur S. Hanes</u>	
ADDRESS		DATE	

CERTIFICATE OF DEATH

1922

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>		<p>4. Date of birth</p>		<p>5. Place of birth</p>	
<p>6. Date of death</p>		<p>7. Place of death</p>		<p>8. Cause of death</p>		<p>9. Duration of illness</p>		<p>10. Name of physician</p>	
<p>11. Name of informant</p>		<p>12. Address of informant</p>		<p>13. Signature of informant</p>		<p>14. Signature of physician</p>		<p>15. Signature of registrar</p>	



RECEIVED
 1922
 JAN 10 1922
 BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01542

1548 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsville RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsville RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 289 - White Mt. Station</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles S. Wilson</u>		4. DATE OF DEATH <u>February 3, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Oct. 1874</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Elm, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Wilson</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>(Unknown)</u>	
17. INFORMANT <u>Mr. Charles S. Wilson</u>		Address <u>Seneca #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>72 hrs.</u> <u>104 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sonitizing</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> to <u>2/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Prichard</u>		M.D. <u>715 Cotter Rd</u> <u>2/3/60</u>	
PHYSICIAN'S NAME (Type) <u>R. W. Prichard</u>		ADDRESS (Street, city or town, state) <u>9104 Burnie, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6 Feb. 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elm Haven Cpn.</u>		22d. LOCATION (City, town, or county) (State) <u>Elm, Burnie, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. P. Singleton</u>		ADDRESS <u>Elm, Burnie, Md</u>	
24a. REC'D BY REGISTRAR <u>Feb 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

CERTIFICATE OF DEATH

1900

LAMAR BOYD

Age 10

Male

White

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01543

1543 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benfield Rd.</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Box 403 millersville</u>	
3. NAME OF DECEASED (Type or print) <u>Irene Leah Wocken FUSS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1919</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Churchville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>? J.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Husband - Wm Wocken Fuss</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19, to <u>1960</u> , 19, that I last saw the deceased alive on <u>3 Feb</u> 19 <u>60</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert P. Hahn, M.D. Seerma Park Md</u> 2-19-60			
ACTUAL SIGNATURE <u>Robert P. Hahn</u>		PHYSICIAN'S NAME (Type) <u>Robert P. Hahn</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 23-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 24 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

15-538

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1922

WALKER
BOMD

15-538
CONTINUED

NAME OF DECEASED		WALKER, BOMD	
AGE		24	
SEX		M	
RACE		W	
DATE OF DEATH		JAN 24 1922	
PLACE OF DEATH		BALTIMORE, MD	
CAUSE OF DEATH		TUBERCULOSIS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. WALKER	
SIGNATURE OF REGISTRAR		J. H. WALKER	
SIGNATURE OF WITNESSES		J. H. WALKER	
SIGNATURE OF DECEASED		J. H. WALKER	
SIGNATURE OF NEXT OF KIN		J. H. WALKER	
SIGNATURE OF BURIAL OFFICIAL		J. H. WALKER	
SIGNATURE OF CLERGYMAN		J. H. WALKER	
SIGNATURE OF MINISTER		J. H. WALKER	
SIGNATURE OF CHURCH		J. H. WALKER	
SIGNATURE OF FUNERAL HOME		J. H. WALKER	
SIGNATURE OF CEMETERY		J. H. WALKER	
SIGNATURE OF INTERMENT		J. H. WALKER	
SIGNATURE OF BURIAL		J. H. WALKER	
SIGNATURE OF CREMATION		J. H. WALKER	
SIGNATURE OF OTHER		J. H. WALKER	

CERTIFICATE OF DEATH

Reg. Dist. No. **01544**

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 CARVER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH Elizabeth Wright		4. DATE OF DEATH Feb 24 1960	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20-1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) A. A. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Chambers		14. MOTHER'S MAIDEN NAME Louise Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-9511	
17. INFORMANT Louise B. Carroll - 7 Carver St.		Address ANNAPOLIS Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma following 199.2 DUE TO Total abdominal hysterectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 months (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 3, 1960 to Feb 24, 1960 , that I last saw the deceased alive on Feb 24, 1960 , and that death occurred at 9:10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ruth Beckman		ADDRESS (Street, city or town, state) 110 - clay St Annapolis, Md	
PHYSICIAN'S NAME (Type) C. E. Hicks		DATE SIGNED Feb 24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 29-60	22c. NAME OF CEMETERY OR CREMATORY U. S. NATIONAL	22d. LOCATION (City, town, or county) (State) ANNAPOLIS - Md.
23. BURIAL DIRECTOR'S SIGNATURE C. E. Hicks		24. REC'D BY REGISTRAR Arthur S. Kims	
ADDRESS ANNAPOLIS - Md.		DATE MAR 1 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-24

EXHIBIT D - DEATH

100

REC'D IN ADM

CHIEF OF POLICE

CHIEF OF POLICE

Mr. Charles Chambers
1212 1/2 Avenue C
San Francisco, Calif. 94114

San Francisco, Calif. 94114
1212 1/2 Avenue C
Mr. Charles Chambers

1550 CERTIFICATE OF DEATH

Reg. Dist. No.

01545

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Disney Road</u>		d. STREET ADDRESS <u>1 Disney Road</u>	
3. NAME OF DECEASED (Type or print) <u>John W. Zepp</u>		4. DATE OF DEATH <u>February 7 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 January 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>7</u> Days <u>19</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Catroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Zepp</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jameson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-13-7984</u>	
17. INFORMANT <u>Mrs. Grace H. Zepp - Same As #2</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X Cardio-Vascular Disease</u> DUE TO <u>Coronary Arteriosclerosis & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Grippe</u> (b) <u>Grippe</u> (c) <u>Grippe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>10 days</u> <u>3-4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> to <u>2/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/7/60</u> , 19 <u>60</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball, Jr.</u>		ADDRESS (Street, city or town, state) <u>Linthicum Heights, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles L. Ball, M.D.</u>		DATE SIGNED <u>2/8/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10 Feb. 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u>		24a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1491

CERTIFICATE OF DEATH

01546

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burien Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burien Beach, Pasadena P.O. Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>8576 Main Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Peter A.</i> Middle <i>Zerhusen</i> Last		4. DATE OF DEATH Month <i>Feb</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-3-1884</i>
9. AGE (In years lost birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>12</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <i>Ret. Balt. Transit</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Zerhusen</i>		14. MOTHER'S MARRIEN NAME <i>Katherine Streb</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Barbara M. Zerhusen</i>	
17. INFORMANT <i>Barbara M. Zerhusen</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cerebral thrombosis</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis, generalized</i> DUE TO (c) <i>2 months</i> <i>2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 10, 1949</i> to <i>February 12, 1960</i> , that I last saw the deceased alive on <i>February 11, 1960</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>R.F.D. Box 442, Pasadena, Md. Feb. 12, 1960</i>	
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>2-16-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hartford Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hana</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

